

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the

OMB Nos. 1210 - 0110 1210 - 0089

2016

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

	I · Annual Report Identification Inf calendar plan year 2016 or fiscal plar		tne instructions to the Form 55		2016		
A a multiple-employer plan (Filers checking this box must attach a list of participat employer information in accordance with the form instructions) for			t attach a list of participating	☐ a multiemployer plan; ☑ a single- employer plan;	☐ a multiple-☐ a DFE (sp	☐ a multiple-employer plan; ☐ a DFE (specify)	
ВТ	his return/report is:			the first return/report; an amend return/report;	a short pla		
C If	the plan is a collectively-bargained plan	n, check here		_	_	_	
D C	heck box if filling under:			X Form 5558	8;	the DFVC program;	
				special ex	tension (enter descrip	· -	
Part	II · Basic Plan Information – enter	all requested i	nformation.			,	
1a	Name of plan				1b Three-digit plan number (PN	501	
	FABSOUTH LLC PREMIUM CONVER	RSION PLAN		:	1c Effective date of May 17, 2004		
2a	Plan sponsor's name and address, inc plan)	cluding room o	r suite number (Employer, if for a sinc		2b Employer Identification 1961		
	FABSOUTH LLC 721 NE 44TH STREET FT. LAUDERDALE FL 33334-3150			_	 2c Sponsor's telepho 954-938-5800 2d Business code (s 332300 		
Unde sche	tion: A penalty for the late or incompleter penalties of perjury and other penaltidules, statements and attachments, as ect, and complete.	es set forth in	the instructions, I declare that I have e ectronic version of this return/report, a	examined this re	eturn/report, including		
		09/06/2017	TIMOTHY BURNS				
	Signature of plan administrator	Date	Enter name of individual signing as p	olan administrato	or		
•	Signature of employer/plan sponsor	Date	Enter name of individual signing as o sponsor	employer or plai	n		
•	Oimatus (DEE			DEE			
Ec. '	Signature of DFE	Date	Enter name of individual signi	•		Eorm <i>EE</i> 00 (2040)	
ror	Paperwork Reduction Act Notice and					Form 5500 (2016) v.092308.1	
3a	Plan administrator's name and addres	s (if same as p	plan sponsor, enter"Same")		3b Administrator's E3c Administrator's te		

6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines 6a(1), 6a(2), 6b, 6c, and 6d)		
a(1) Total active number of participants at the beginning of the plan year	6a(1)	862
a(2	Total active number of participants at the end of the plan year	6a(2)	
b d	Retired or separated participants receiving benefits	6b	4
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	834
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h _	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7 .	0
8a	If the plan provides <u>pension benefits</u> , enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:		
_			
b	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:		
	<u>4A 4B 4D 4E 4F 4H 4L </u>		
() () () (4 10 C	Plan funding arrangement (check all that apply) 1) Insurance 2) Section 412(e)(3) insurance contracts 3) Trust 4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, equations)	ance contracts	attached (See
	Pension Schedules 1) ☐ R (Retirement Plan Information) b General Schedules (1) ☐ H (Financial Informati	on)	
	2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary (3) 8 A (Insurance Information) (4) C (Service Provider In Company Comp	tion) nformation)	
(-	3) SB (Single-Employer Defined Benefit Plan Actuarial Information) (5) D (DFE/Participating - signed by the plan actuary (6) G (Financial Transact		
Par	t III Form M-1 Compliance Information (to be completed by welfare benefit plans)	1011 00110001100)	
11 a	If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan instructions and 29 CFR 2520.101-2) ☐ Yes No If "Yes" is checked, complete lines 11b and 11c.		
11k 11c	b Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.101- Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was required Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5 as incomplete.) Receipt Confirmation Code	file the 2016 to be filed under t	he

865

SCHEDULE A Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

FABSOUTH LLC PREMIUM CONVERSION	PI AN
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C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

FABSOUTH LLC

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

AIG	INSUR	ANCE	COMP	ANY	OF	CANADA	4
					•	·	•

/L\ =\\	(-) NIAIO	(d) Contract or	(e) Aproximate number of	Policy or contract year		
(b) EIN	(c) NAIC code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
8210	19402	BSC 9022705A	830	01/01/2016	12/31/2016	

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

- 3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker or other person to whom commissions or fees were paid

 - (b) Amount of sales and base commissions paid

Fees and other commissions paid (c) Amount (d) Purpose (e) Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v.092308.1

7b

as a unit for

investment and Annuity Contract ini	ormation	
Where individual contracts are provided	d, the entire group of such individual contracts with each carrier may be t	reated

purposes of this report.	
Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5
6 Contracts With Allocated Funds	
a State the basis of premium rates	
b Premiums paid to carrier	6b
c Premiums due but unpaid at the end of the year	6c
d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount	6d
Specify nature of costs	
e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)	
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	

- (1) ☐ deposit administration (2) ☐ immediate participation guarantee
- (3) ☐ guaranteed investment (4) ☐ other

Balance at the end of the previous year Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4) (5) Other (specify below) 7c(5)

(6) Total additions 7c(6)

	Case 1:18-cv-01805- Total of balance and additions (add b and c (6))	JGK I	Oocunsteety is 14	Tree हमार्थि 03/07/18	Page 4 of	91 7d	
	Deductions: (1) Disbursed from fund to pay benefits or purcha (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below)	se annuiti	es during year		7e 7e 7e	(2) (3)	
f	(5) Total deductions Balance at the end of the current year (subtract e Welfare Benefit Contract Information If more than one contract covers the same			como employer(a) er membro	ers of the san	7e(5) 7f	
	rt III employee organization(s), the information may as a unit. Where contracts cover individual e be treated as a unit for purposes of this repo	ay be com mployees rt.	bined for reporting	purposes if such contracts	are experienc	e-rated	
8	Benefit and contract type (check all applicable box a Health (other than dental or vision)	(es) Denta	al	c Vision	Ь	Life insurar	nce
	Taman anamy dia a b liliby						
	(<u>ac</u> cident and sickness)	•	term disability	g Supplemental unemplo	-	Prescription	_
		ј □ нмо		k ☐ PPO contract	I	☐ Indemnity of	contract
	m ☑ Other (specify) ACCIDENTAL DEATH AND	DISMEMI	BERMENT				
9	Experience related contracts						
	Premiums: (1) Amount received				9a(1)	1	
	(2) Increase (decrease) in amount due but unpaid				9a(2)		
	(3) Increase (decrease) in unearned premium res	erve			9a(3)	1	
	(4) Earned ((1)+(2)-(3))					9a(4)	
b	Benefit charges: (1) Claims paid				9b(1))	
	(2) Increase (decrease) in claim reserves				9b(2)	1	
	(3) Incurred claims (add (1) and (2))					9b(3)	
	(4) Claims charged					9b(4)	
С	Remainder of premium: (1) Retention charges (o	n an accru	ual basis) –		• (1)(
	(A) Commissions				9c(1)(/		
	(B) Administrative service or other fees				9c(1)(E		
	(C) Other specific acquisition costs (D) Other expenses				9c(1)(0	•	
	(E) Taxes				9c(1)(I 9c(1)(I	•	
	(F) Charges for risks or other contingencies				9c(1)(I		
	(G) Other retention charges				9c(1)(0		
	(H) Total Retention					9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These a	amounts v	ere Doaid in cas	h. or Credited.)		9c(2)	
d	Status of policyholder reserves at end of year: (1					9d(1)	
	(2) Claim reserves	,	•			9d(2)	
	(3) Other reserves					9d(3)	
	Dividends or retroactive rate refunds due. (Do no	t include a	amount entered in	c(2).)		9e	
	Nonexperience-rated contracts						
	Total premiums or subscription charges paid to c					10a	\$9,720
b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo Specify nature of costs below:				r	10b	
_							
	rt IV Provision of Information	··		1-4- O-b AO		П.,	. .
	Did the insurance company fail to provide any inf			iete Schedule A'?		∐Ye	s 🔀 No
12	If the answer to line 11 is "Yes," specify the inform	nation not	proviaea.				

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

01/01/2016

501

12/31/2016

FABSOUTH LLC PREMIUM CONVERSION PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

67369

D Employer Identification Number (EIN)

FABSOUTH LLC

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

1071

descending order of the amount paid.

(a) Name of insurance carrier

CIGNA HEALTH AND LIFE INSURANCE COMPANY AND AFFILIATES

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in

(a) Total amount of commissions paid

(b) Total amount of fees paid

1323

\$160,309 \$3,464

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

2499612

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base Fees and other commissions paid commissions paid (c) Amount (d) Purpose

SERVICE/GEN AGENT FEES

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

\$3,464

Schedule A (Form 5500) 2016 v 092308 1

6b

6c

6d

(e) Organization

code

Invoctment	and	A nouity	Contract	Information
IIIVESHIEHL	anu	AIIIIUILV	CUIILIACE	IIIIOIIIIauoii

\$160,309

Part II	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated	as a unit for
	purposes of this report.	
Curr	ent value of plan's interest under this contract in the general account at year end	4
Curr	rent value of plan's interest under this contract in separate accounts at year end	5

Current value of plan's interest under this contract in separate accounts at year end 6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year d If the carrier, service, or other organization incurred any specific costs in connection with the acquision

or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other

Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2)

(3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/2018	8 Other (specify	Case 1:18-cv-01805 below)	-JGK	Document/iew	는 Tee F대는 선 03/07/18	Page 6	of 9		
d To	Total additions tal of balance adductions:	s and additions (add b and c (6))						7c(6) 7d	
(1) (2) (3)	Disbursed from Administration	n fund to pay benefits or purcha charge made by carrier separate account below)	ase annu	iities during year			7e(1 7e(2 7e(3 7e(4	2) 3)	
	Welfare I	d of the current year (subtract of Benefit Contract Information		•				7e(5) 7f	
	ll employee or as a unit. Wh be treated as	an one contract covers the san ganization(s), the information mere contracts cover individual of s a unit for purposes of this repond to type (check all applicable bo	nay be co employee ort.	mbined for reporting	purposes if such contracts	are expe		-rated	
	🔼 Health (othe	er than dental or vision)	b 🔀 Der	ntal	c Vision		d [Life insura	ince
e /	☐ Temporary accident and s	disablility ickness)	f Lon	g-term disability	g Supplemental unempl	oyment	h 🏻	Prescription	on drug
i		arge deductible)	j 🔀 HM	O contract	k ☐ PPO contract		I	Indemnity	contract
a Pr (2)	Increase (deci	d contracts mount received rease) in amount due but unpai rease) in unearned premium re				9:	a(1) a(2) a(3)	\$5,852,110	
b Be (2)	Increase (deci	(1) Claims paid rease) in claim reserves					b(1) b(2)	9a(4) \$5,412,398 \$51,420	\$5,852,110
(4)	Claims charge							9b(3) 9b(4)	\$5,463,818 \$5,463,818
() (I)	A) Commissior B) Administrati	emium: (1) Retention charges (ns ve service or other fees fic acquisition costs	on an ac	crual basis) –		9c((1)(A) (1)(B) (1)(C)	\$147,471	
(I (I (I	D) Other exper E) Taxes	risks or other contingencies				9c(9c(9c((1)(D) (1)(E) (1)(F) (1)(G)	\$864,747 \$117,042	
(2)		tion etroactive rate refunds. (These older reserves at end of year: (9c(1)(H) 9c(2) 9d(1)	\$1,129,260
(2) (3)	Claim reserve Other reserve	s						9d(2) 9d(3) 9e	\$937,152
	onexperience-r	ated contracts or subscription charges paid to o	rarrier					10a	\$951,221
b If the	the carrier, ser	vice, or other organization incur ontract or policy, other than rep	red any			Γ		10b	ψ 3 01,221
Dowt II	V Dravisla	a of Information							

Provision of Information

Did the insurance company fail to provide any information necessary to complete Schedule A?If the answer to line 11 is "Yes," specify the information not provided.

☐Yes X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

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Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

12/31/2016

FABSOUTH LLC PREMIUM CONVERSION PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

FABSOUTH LLC

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 65498 FLI960258 830

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

01/01/2016

\$2,136

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$2,136

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

	Investment and Annuity Contract Information
Part II	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated

Part II Where individual contracts are provided, the entire group of such individual contracts with each carrier n	may be treated as a unit for
purposes of this report.	
Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5
6 Contracts With Allocated Funds	
a State the basis of premium rates	
b Premiums paid to carrier	6b
c Premiums due but unpaid at the end of the year	6c
d If the carrier, service, or other organization incurred any specific costs in connection with the acquision	6d
or retention of the contract or policy, enter amount	60
Specify nature of costs	

e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other

Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2)

(3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Documatentyiew	4-PreeFRIed 03/07/18 Page	e 8 of 91 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:				7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purcha(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	ase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
f	(5) Total deductions Balance at the end of the current year (subtract of the Welfare Benefit Contract Information of the contract covers the same statement of the contract covers the cov		e same employer(s) or members of the	e same	7e(5) 7f	
	art III employee organization(s), the information m as a unit. Where contracts cover individual of be treated as a unit for purposes of this repo Benefit and contract type (check all applicable bo	nay be combined for reportin employees, the entire group ort.	g purposes if such contracts are earlier and individual contracts with earlier	xperience-ra ach carrier n	nay	
	\	b Dental	c	d 🔀	Life insurar	nce
	e ☐ Temporary disablility (accident and sickness)	f ☐ Long-term disability	g ☐ Supplemental unemployment	h 🗌	Prescriptior	n drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO contract	Ι□	Indemnity o	contract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpai (3) Increase (decrease) in unearned premium re-			9a(1) 9a(2) 9a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves			9b(1) 9b(2)	9a(4)	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged				9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis) –			30(4)	
	(A) Commissions (B) Administrative service or other fees			9c(1)(A) 9c(1)(B)		
	(C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies			9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F)		
	(G) Other retention charges			9c(1)(G)		
	(H) Total Retention				9c(1)(H)	
٨	(2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: (amounts were paid in ca	sh, or		9c(2) 9d(1)	
u	(2) Claim reserves (3) Other reserves	T) Amount held to provide be	enems alter retirement		9d(2) 9d(3)	
	Dividends or retroactive rate refunds due. (Do n	ot include amount entered in	c(2).)		9e	
	Nonexperience-rated contracts Total premiums or subscription charges paid to	carrier			10a	\$182.678
	If the carrier, service, or other organization incur retention of the contract or policy, other than rep Specify nature of costs below:	rred any specific costs in cor			10b	* ,
D.	art IV · Provision of Information					
	Did the insurance company fail to provide any in	formation necessary to com	plete Schedule A?		□Ye	s 🔀 No

- Did the insurance company fail to provide any information necessary to complete Schedule A?If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

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B Three-digit plan number (PN)

01/01/2016

501

12/31/2016

FABSOUTH LLC PREMIUM CONVERSION PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

65498

D Employer Identification Number (EIN)

FABSOUTH LLC

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$2,000

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

LK 751892

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

830

(e) Organization code

\$2,000

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

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Investment	al A	 ·	l £	4:

	which individual contracts are provided, the critic group of such individual contracts with each carrier may be treated	as a unit ioi
	purposes of this report.	
Curre	ent value of plan's interest under this contract in the general account at year end	4
·	untivalva of plants interest under this sentuat in sensuate security of year and	_

Current value of plan's interest under this contract in separate accounts at year end

6 Contracts With Allocated Funds a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year Additions: (1) Contributions deposited during the year 7c(1)

(2) Dividends and credits 7c(2) (3) Interest credited during the year (4) Transferred from separate account 7c(4)

3/6/2	Case 1:18-cv-01805- (5) Other (specify below)	JGK Doculnste	ιϻϯϯ ϒϳ <u>Ϸ</u> ϗϒͺ϶· <u>ϯ</u> ʹϝϲ϶ ϥ Ε	R€0 03/07/18	Page 10	of 91 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:					7c(\ 7d	•	
	(1) Disbursed from fund to pay benefits or purch.(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	ase annuities during y	/ear			7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the san rt III employee organization(s), the information in as a unit. Where contracts cover individual of	ne group of employee nay be combined for it employees, the entire	eporting purpor	ses if such contracts	are experi	7e(: 7f same ience-rated carrier may		
8	be treated as a unit for purposes of this repo Benefit and contract type (check all applicable bo							
	a ☐ Health (other than dental or vision)	b Dental	c □ \	/ision		d Life ins	urance	
	e X Temporary disablility (accident and sickness)	f ☐ Long-term disab	oility g 🗌 S	Supplemental unemp	oloyment	h Prescri	ption d	rug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k 🗌 F	PPO contract		I ☐ Indemr	ity con	tract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpai (3) Increase (decrease) in unearned premium re				9	a(1) a(2) a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid				9	9a(4) b(1)	1	
	(2) Increase (decrease) in claim reserves				9	b(2)		
	(3) Incurred claims (add (1) and (2)) (4) Claims charged					9b(3 9b(4		
С	Remainder of premium: (1) Retention charges (on an accrual basis) -	-		0-			
	 (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges 				9c) 9c) 9c) 9c	(1)(A) (1)(B) (1)(C) (1)(D) (1)(E) (1)(F) (1)(G)		
	(H) Total Retention				30,	9c(1)(H)	
	 (2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: ((2) Claim reserves (3) Other reserves 	1) Amount held to pro	ovide benefits a	credited.) fter retirement		9c(2 9d(1 9d(2 9d(3))	
	Dividends or retroactive rate refunds due. (Do n Nonexperience-rated contracts	ot include amount en	tered in c(2).)			9e		
а	Total premiums or subscription charges paid to a lift the carrier, service, or other organization incurretention of the contract or policy, other than rep Specify nature of costs below:	red any specific cost			or	10a 10b	\$1	70,854
	, ,							
11	rt IV Provision of Information Did the insurance company fail to provide any ir If the answer to line 11 is "Yes," specify the infor	-	to complete Sc	hedule A?]Yes	X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

01/01/2016

501

12/31/2016

FABSOUTH LLC PREMIUM CONVERSION PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

65498

D Employer Identification Number (EIN)

FABSOUTH LLC

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

Part II

(a) Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in

descending order of the amount paid.

830

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$1,275

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

LK 964791

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$1,275

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

7b

7c(4)

as a unit for

1	and Annuity	^ 4 · 4 · I ·	- f 4!
INVASTMANT	and Annility	Contract II	ntormation

purposes of this report.	•
4 Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated

6 Contracts With Allocated Funds a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year

Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3)

(4) Transferred from separate account

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Doculnstentivi	e4-freqER& 03/07/18	Page 12 of 93 7c(5)	1	
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:))			7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa		the same employer(s) or memb	ers of the same	7e(5) 7f	
	Irt III employee organization(s), the information as a unit. Where contracts cover individual be treated as a unit for purposes of this replacement and contract type (check all applicable beginning).	may be combined for repor employees, the entire grou port. oxes)	ting purposes if such contracts up of such individual contract	are experience-rass with each carrier r	may	
	a Health (other than dental or vision)	b Dental	c Vision	d □	Life insurand	ce
	e ☐ Temporary disablility (accident and sickness)	f I Long-term disability	g Supplemental unempl	oyment h	Prescription	drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO contract	ı	Indemnity co	ontract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re			9a(1) 9a(2) 9a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))			9b(1) 9b(2)	9a(4)	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged				9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges	(on an accrual basis) -		0 (4)(4)	• •	
	(A) Commissions (B) Administrative service or other fees			9c(1)(A) 9c(1)(B)		
	(C) Other specific acquisition costs			9c(1)(C)		
	(D) Other expenses (E) Taxes			9c(1)(D) 9c(1)(E)		
	(F) Charges for risks or other contingencies			9c(1)(F)		
	(G) Other retention charges (H) Total Retention			9c(1)(G)	0~(4)/[])	
	(2) Dividends or retroactive rate refunds. (These	e amounts were \square paid in	cash or Credited)		9c(1)(H) 9c(2)	
d	Status of policyholder reserves at end of year:	(1) Amount held to provide	benefits after retirement		9d(1)	
	(2) Claim reserves (3) Other reserves				9d(2) 9d(3)	
е	Dividends or retroactive rate refunds due. (Do	not include amount entered	in c(2).)		9e	
	Nonexperience-rated contracts				40-	# 400 040
	Total premiums or subscription charges paid to If the carrier, service, or other organization incu		onnection with the acquisition o	or		\$108,948
	retention of the contract or policy, other than re Specify nature of costs below:				10b	
P:	rt IV · Provision of Information					
	Did the insurance company fail to provide any i	nformation necessary to co	mplete Schedule A?		☐Yes	X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

This Form is Open to Public Inspection

OMB No. 1210 - 0110

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

01/01/2016

501

12/31/2016

FABSOUTH LLC PREMIUM CONV	/ERSION	PLAN
---------------------------	---------	------

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

FABSOUTH LLC

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

LIFE INSURANCE COMPANY OF NORTH AMERICA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 65498 OK 968488 830

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$248

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$248

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

Investment and Annuity Contract Information
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated

Par	rt II Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated	d as a unit for
	purposes of this report.	
4 C	current value of plan's interest under this contract in the general account at year end	4
5 C	current value of plan's interest under this contract in separate accounts at year end	5
6 0	Contracts With Allocated Funds	

a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee

	(3)		
b	Balance at the end of the previous year		7b
С	Additions: (1) Contributions deposited during the year	7c(1)	

(2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	Case 1:18-cv-01805- (5) Other (specify below)	JGK Docu inster iti ^v ⊉¥	-fre ∉R&d 03/07/18 Page	14 of 93 7c(5)	1	
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:				7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purchal (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below)	ase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract of the welfare Benefit Contract Information of the contract covers the same of the third that it is a substitution of the third that is a substitution of the current year (subtract of the current year) of the third that is a substitution of the current year (subtract of the current year) of the third that is a substitution of the current year (subtract of the current year) of the third that is a substitution of the current year (subtract of the current year) of the third that is a substitution of the current year (subtract of the current year) of the third that is a substitution of the current year (subtract of the current year) of the cur	ne group of employees of the ay be combined for reporting	g purposes if such contracts are ex	kperience-ra		
8	as a unit. Where contracts cover individual e be treated as a unit for purposes of this repo Benefit and contract type (check all applicable box	ort.	_		-	
	_ \	b Dental	c	d 📙	Life insuranc	е
	e Temporary disablility (accident and sickness)	f ☐ Long-term disability	g Supplemental unemployment	h 🗌	Prescription (drug
	i ☐ Stop loss (large deductible) m ☑ Other (specify) ACCIDENTAL DEATH AND	j HMO contract DISMEMBERMENT	k ☐ PPO contract	Ι□	Indemnity co	ntract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpair (3) Increase (decrease) in unearned premium res			9a(1) 9a(2) 9a(3)		
h	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid			9b(1)	9a(4)	
b	(2) Increase (decrease) in claim reserves			9b(2)		
	(3) Incurred claims (add (1) and (2))				9b(3)	
c	(4) Claims charged Remainder of premium: (1) Retention charges (c	on an accrual hasis) –			9b(4)	
Ŭ	(A) Commissions	on an addition badio)		9c(1)(A)		
	(B) Administrative service or other fees			9c(1)(B)		
	(C) Other specific acquisition costs (D) Other expenses			9c(1)(C) 9c(1)(D)		
	(E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges			9c(1)(E) 9c(1)(F) 9c(1)(G)		
	(H) Total Retention				9c(1)(H)	
d	(2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: (*) Claim reserves	amounts were ∐ paid in cas 1) Amount held to provide be	sh, or		9c(2) 9d(1) 9d(2)	
е	(3) Other reserves Dividends or retroactive rate refunds due. (Do no	ot include amount entered in	c(2).)		9d(3) 9e	
10	Nonexperience-rated contracts		() ,			
	Total premiums or subscription charges paid to of the carrier, service, or other organization incur retention of the contract or policy, other than rep Specify nature of costs below:	red any specific costs in con			10a 10b	\$21,152
Da	rt IV · Provision of Information					
11	Did the insurance company fail to provide any in If the answer to line 11 is "Yes," specify the infor		plete Schedule A?		Yes	X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

01/01/2016

501

FABSOUTH LLC PREMIUM CONVERSION PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

79413

D Employer Identification Number (EIN)

FABSOUTH LLC

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

UNITEDHEALTHCARE INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$518 \$46

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

0755852

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 1560 SAWGRASS CORP PKWY STE 300 SUNRISE FL 33323

(b) Amount of sales and base commissions paid

Fees and other commissions paid (c) Amount

(e) Organization code

3

\$518

\$46

(d) Purpose SERVICE FEE AGREEMENT

830

01/01/2016

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

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Investment and Annuity Contract Information
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated

raitii	where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated	as a unit ioi
	purposes of this report.	
1 Curre	ent value of plan's interest under this contract in the general account at year end	4
5 Curre	ent value of plan's interest under this contract in separate accounts at year end	5

6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c If the carrier, service, or other organization incurred any specific costs in connection with the acquision

or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other

Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2)

(3) Interest credited during the year (4) Transferred from separate account 7c(4)

3/6/	Case 1:18-cv-01805 (5) Other (specify below)	-JGK Docul	nsentvieu-	£re∉R&∂ 03/07/18	Page 16 of		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)				7c(6) 7d	
Ū	(1) Disbursed from fund to pay benefits or purcl (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below)	nase annuities dur	ing year		7e(* 7e(* 7e(* 7e(*	2) 3)	
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information		ayaaa af tha s	omo omplovor(a) ar momb	ore of the	7e(5) 7f	
	If more than one contract covers the sa art III employee organization(s), the information as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable b	may be combined employees, the electric endings and the electric end of the electric e	for reporting	purposes if such contracts	are experience	-rated	
Ü	a X Health (other than dental or vision)	b Dental		c Vision	d [Life insurar	ice
	Temporary disablility	f ☐ Long-term o	disability	g Supplemental unemp	_	Prescription	
	(accident and sickness) i □ Stop loss (large deductible)	j ☐ HMO contra	-	k ☐ PPO contract	-	Indemnity o	•
	m Other (specify)	, I I I I I I I I I I I I I I I I I I I	101	Mari o contract	• •	_ macming c	ontiact
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re				9a(1) 9a(2) 9a(3)	00(4)	
b	 (4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2)) (4) Claims charged 				9b(1) 9b(2)	9a(4) 9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges (A) Commissions (B) Administrative service or other fees	(on an accrual bas	sis) –		9c(1)(A 9c(1)(B)	
	(C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges				9c(1)(C 9c(1)(D 9c(1)(E 9c(1)(F 9c(1)(G)))	
d	(H) Total Retention (2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: (2) Claim reserves					9c(1)(H) 9c(2) 9d(1) 9d(2)	
	(3) Other reserves Dividends or retroactive rate refunds due. (Do Nonexperience-rated contracts	not include amoun	it entered in c	(2).)		9d(3) 9e	
а	Total premiums or subscription charges paid to			e 20 0 1 2 22		10a	\$4,991
b	If the carrier, service, or other organization incuretention of the contract or policy, other than re Specify nature of costs below:	ırred any specific oported in Part I, ite	costs in conne em 2 above, r	ection with the acquisition c eport amount	or	10b	
	art IV · Provision of Information					_	
11	Did the insurance company fail to provide any i	nformation necess	sary to comple	ete Schedule A?		∐ Ye	s ื No

SCHEDULE A Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

	fit Guaranty Corporation		ERISA section 103(a)(2).		
For the calendar			01, 2016, and ending December 3	1, 2016	
A Name of plan				B Three-digit plan number (PN)	
FABSOUTH LLC	PREMIUM CONVERS	ION PLAN		pian number (FIV)	501
C Plan sponsor's n	name as shown on line 2	a of Form 5500		D Employer Identificat	ion Number (EIN)
FABSOUTH LLC				1961	
	parate Schedule Ā. Indiv nation		and Commissions.Provide information Parts II and III can be reported o		
		VISION SEI	RVICE PLAN		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or co (f) From	ntract year (g) To
0825	32395	30061141	577	01/01/2016	12/31/2016
		on. Enter the total fees and total c	commissions paid. List in item 3 the	agents, brokers, and otl	ner persons in
descending order of	of the amount paid. (a) Total amount of com	ımissions paid	(b) Total an	nount of fees paid	
3 Persons receivir		s. (Complete as many entries as ddress of the agent, broker or oth	needed to report all persons). er person to whom commissions or	fees were paid	
	mount of sales and base commissions paid	Fees (c) Amoun	and other commissions paid (d) Purpose		<u>anization</u> ode
For Paperwork Re	eduction Act Notice an	d OMB Control Numbers, see t	he instructions for Form 5500.	Schedule A (f	Form 5500) 2016 v.092308.1
Part II Where	ment and Annuity Conindividual contracts are of this report.		h individual contracts with each carr	ier may be treated a	s a unit for
4 Current value of	plan's interest under thi	s contract in the general account			4
6 Current value of6 Contracts With A		s contract in separate accounts a	at year end		5
a State the basisb Premiums paid	of premium rates			(6b
c Premiums due	but unpaid at the end of	,			6c
or retention of t	the contract or policy, en	tion incurred any specific costs in ter amount	connection with the acquision	•	6d
Specify nature of e Type of contract	of costs ct (1)	es (2) group deferred annu	ity (3) other (specify)		
7 Contracts With U	Unallocated Funds (Do r ct (1)	rt, to distribute benefits from a tent of include portions of these contributes (2) immediate particles (4) to other	racts maintained in separate accoun	uts)	
	e end of the previous yea	ar		;	7b
	Contributions deposited	during the year		7c(1)	
(2) Dividends a (3) Interest cree	and credits dited during the year			7c(2) 7c(3)	
(4) Transferred	I from separate account			7c(4)	
(5) Other (spec	cify below)			7c(5)	

(6) Total additions

7c(6)

3/6/2018 Case 1:18-cv-01805-JGK Documsent/@4-free=Red 03/07/18 Page 18 of 91 **d** Total of balance and additions (add **b** and **c** (6)) 7d Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year 7e(1) (2) Administration charge made by carrier 7e(2) (3) Transferred to separate account 7e(3) (4) Other (specify below) 7e(4) (5) Total deductions 7e(5) f Balance at the end of the current year (subtract e(5) from d) **Welfare Benefit Contract Information** If more than one contract covers the same group of employees of the same employer(s) or members of the Part III employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. Benefit and contract type (check all applicable boxes) c X Vision d Life insurance **a** Health (other than dental or vision) **b** Dental ☐ Temporary disablility f ☐ Long-term disability $\mathbf{g} \square$ Supplemental unemployment h Prescription drug (accident and sickness) k ☐ PPO contract Stop loss (large deductible) j HMO contract I Indemnity contract m Other (specify) 9 Experience related contracts Premiums: (1) Amount received 9a(1) (2) Increase (decrease) in amount due but unpaid 9a(2) (3) Increase (decrease) in unearned premium reserve 9a(3) (4) Earned ((1)+(2)-(3)) 9a(4) Benefit charges: (1) Claims paid 9b(1) (2) Increase (decrease) in claim reserves 9b(2) (3) Incurred claims (add (1) and (2)) 9b(3) (4) Claims charged 9b(4) Remainder of premium: (1) Retention charges (on an accrual basis) -(A) Commissions 9c(1)(A) 9c(1)(B) (B) Administrative service or other fees (C) Other specific acquisition costs 9c(1)(C) 9c(1)(D) (D) Other expenses (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F) (G) Other retention charges 9c(1)(G) (H) Total Retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were \square paid in cash, or \square credited.) 9c(2) 9d(1) Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement (2) Claim reserves 9d(2) (3) Other reserves 9d(3) Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e Nonexperience-rated contracts Total premiums or subscription charges paid to carrier 10a \$59,505 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, item 2 above, report amount Specify nature of costs below: Part IV Provision of Information □Yes X No 11 Did the insurance company fail to provide any information necessary to complete Schedule A?

http://freeerisa.benefitspro.com/5500/formprint.aspx?DLN=20170906100546P040140258529001

12 If the answer to line 11 is "Yes," specify the information not provided.



Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections

104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110 1210 - 0089

This Form is Open to Public Inspection

Complete all entries in accordance with

			the instructions to the Form 5	500.			
	t I Annual Report Identification In						
•	calendar plan year 2015 or fiscal plan	-	=	· —	_		
	multiple-employer plan (Filers checking mployer information in accordance with			□ a multiemploye plan; ■ a single- employer pla	er □ a	n multiple-emp	
ВТ	his return/report is:			the first return/report; an amenreturn/report;	☐ a ded returr	he final return short plan ye r/report (less t hs).	ar
C If	the plan is a collectively-bargained plan	n, check here					
D C	heck box if filling under:			☐ Form 555	58; □ a exten	utomatic ision;	the DFVC program;
_				☐ special e	extension (ente	er description)
Par		all requested	information.		44	11. 14	
1a	Name of plan ROIG LAWYERS HEALTH AND BEN	EFITS			1c Effectiv	ımber (PN) /e date of plar	501 1
					Decem	ber 01, 2000	
2a	Plan sponsor's name and address, inc plan)	cluding room o	or suite number (Employer, if for a sin	gle-employer	_	119	n Number (EIN)
	ROIG LAWYERS 1255 SOUTH MILITARY TRAIL, SUITE 100 DEERFIELD BEACH FL 33442				954-462	r's telephone 2-0330 s code (see ir	
Und sche	tion: A penalty for the late or incomplet er penalties of perjury and other penalti dules, statements and attachments, as ect, and complete.	es set forth in	the instructions, I declare that I have	examined this	return/report,	including acc	
		06/28/2017	MICHAEL ROSENBE	RG			
•	Signature of plan administrator	Date	Enter name of individual signing as	plan administra	itor		
٠	Signature of employer/plan sponsor	Date	Enter name of individual signing as sponsor	employer or pla	an		
•	Signature of DFE	Date	Enter name of individual sign	ing as DFF			
For	Paperwork Reduction Act Notice and		-	•		Fo	rm 5500 (2015) v.092308.1
3a	Plan administrator's name and address	ss (if same as	plan sponsor, enter"Same")		3b Adminis 3c Adminis	strator's EIN strator's teleph	

0/0/20	Case 1.16-CV-01805-JGK DOCUMENTO PA-109-1096 03/07/18	Page 21 C)) 91
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:	4	4b EIN
	onto the hame, Envand the plan hamber from the last retain/report below.	4	1c PN
	a Sponsor's name	•	
5 6	Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines 6a(1), 6a(2), 6b, 6c, and 6d)	5	260
	Total active number of participants at the beginning of the plan year Total active number of participants at the end of the plan year	6a(1) 6a(2)	257
b` c	Retired or separated participants receiving benefits Other retired or separated participants entitled to future benefits	6b´ 6c	5
d	Subtotal. Add lines 6a(2) , 6b , and 6c Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6d 6e	252
e f	Total. Add lines 6d and 6e	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	0
8a	If the plan provides <u>pension benefits</u> , enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:	l	
b	If the plan provides <u>welfare benefits</u> , enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:		
	<u>4A 4B 4D 4E 4F 4H 4L</u>		
	lan funding arrangement (check all that apply)) <mark>⊠</mark> Insurance	9b Plan be all that	enefit arrangement (check apply)
(2	Section 412(e)(3) insurance contracts	(1) 🔀	Insurance
-	Trust .	(2) ∐	Section 412(e)(3) urance contracts
(4	General assets of the sponsor		Trust
		` '	General assets of the
		spo	onsor
	heck all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where indicated actions)	l, enter the numb	er attached (See
а Р	en <u>sio</u> n Schedules b Gen <u>er</u> al Schedules		
(1) R (Retirement Plan Information) (1) H (Financial Inform	ation)	
(2	Purchase Plan Actuarial Information)- signed by the plan actuary. (2) I (Financial Information Purchase Plan Actuarial Information)- signed by the plan actuary (3) 4 A (Insurance Information Purchase Plan Actuarial Information)	nation)	an)
(3	SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (5) D (DFE/Participatin (6) G (Financial Transa	g Plan Information	
	III Form M-1 Compliance Information (to be completed by welfare benefit plans)	0.40	•
11a	If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan structions and 29 CFR 2520.101-2) Yes No If "Yes" is checked, complete lines 11b and 11c.	an year? (See	
	Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.10		□No
	Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required	to file the 2015	
	Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was require Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form as incomplete.) Receipt Confirmation Code		

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2015 or fiscal plan year beginning December 01, 2015, and ending November 30, 2016 A Name of plan

B Three-digit plan number (PN)

501

ROIG LAWYERS HEALTH AND BENEFITS

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

ROIG LAWYERS

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

FIDELITY SECURITY LIFE INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

VARIOUS 71870 219 12/01/2015 11/30/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$1,809

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYPSHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$1,809

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2015 v 092308 1

7b

oo o unit for

Investment	d A .		^44	1 f + :
investment	and A	nniiitv (L.Ontract	Intormation

raitii	while a markada contracts are provided, the entire group of such individual contracts with each carrier may be treated	as a unit ioi
	purposes of this report.	
4 Curre	ent value of plan's interest under this contract in the general account at year end	4
5 Curre	ent value of plan's interest under this contract in separate accounts at year end	5

6 Contracts With Allocated Funds

a State the basis of premium rates **b** Premiums paid to carrier

6b c Premiums due but unpaid at the end of the year 6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year Additions: (1) Contributions deposited during the year 7c(1)

(2) Dividends and credits 7c(2) (3) Interest credited during the year (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805- (5) Other (specify below)	-JGK Docu insen tt ^v i⊵v	r-fre∉ FRed 03/07/18 Page	23 of 91 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)			7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	ase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sai		e same employer(s) or members of the	e same	7e(5) 7f	
	art III employee organization(s), the information r as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable be	nay be combined for reportin employees, the entire group ort.	g purposes if such contracts are ex of such individual contracts with ea	perience-rat ich carrier m	ay	
	a Health (other than dental or vision)	b Dental	c 🔀 Vision	d□L	ife insuranc	е
	e ☐ Temporary disablility (accident and sickness)	f ☐ Long-term disability	g Supplemental unemployment	h∏F	Prescription of	drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO contract	I 🗌 lı	ndemnity co	ntract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re			9a(1) 9a(2) 9a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves			9b(1) 9b(2)	9a(4)	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged				9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges	(on an accrual basis) –			•=(:)	
	(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs			9c(1)(A) 9c(1)(B) 9c(1)(C)		
	(D) Other expenses (E) Taxes (F) Charges for risks or other contingencies			9c(1)(D) 9c(1)(E) 9c(1)(F)		
	(G) Other retention charges (H) Total Retention			9c(1)(G)	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	amounts were \square paid in ca	sh, or ☐ credited.)		9c(2)	
d	Status of policyholder reserves at end of year: (2) Claim reserves (3) Other reserves	(1) Amount held to provide be	enefits after retirement		9d(1) 9d(2) 9d(3)	
	Dividends or retroactive rate refunds due. (Do r	not include amount entered in	n c(2).)		9e	
	Nonexperience-rated contracts Total premiums or subscription charges paid to	carrier			10a S	\$18,004
	If the carrier, service, or other organization incuretention of the contract or policy, other than respectify nature of costs below:	rred any specific costs in cor			10b	, 10,001
D:	art IV · Provision of Information					
	Did the insurance company fail to provide any i	nformation necessary to com	plete Schedule A?		Yes	X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2015 or fiscal plan year beginning December 01, 2015, and ending November 30, 2016 A Name of plan

B Three-digit plan number (PN)

501

ROIG LAWYERS HEALTH AND BENI	EFIIS
------------------------------	-------

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

ROIG LAWYERS

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

3390 64246 00505636 200 12/01/2015 11/30/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid \$1,027

\$11,033

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons). (a) Name and address of the agent, broker or other person to whom commissions or fees were paid

> MERCER HEALTH AND BENEFITS, LLC ONE INVESTORS WAY NORWOOD MA 02062

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$11,033

\$1,027

FEES

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2015 v 092308 1

1 4		A!4	A 4 4	1
investmen	t and	Annuity	Contract	Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. 4 Current value of plan's interest under this contract in the general account at year end

Current value of plan's interest under this contract in separate accounts at year end

5

6d

6 Contracts With Allocated Funds a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c

If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other

Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2)

(3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Docu instein th	″ <u>e</u> ¥-£re ∉R&∂ 03/0	07/18 Page	25 of 91 7c(5)	L	
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:))				7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	hase annuities during year			7e(1) 7e(2) 7e(3) 7e(4)		
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa		the same employer(s)	or members of the	same	7e(5) 7f	
	rt III employee organization(s), the information as a unit. Where contracts cover individual be treated as a unit for purposes of this replace. Benefit and contract type (check all applicable benefit)	may be combined for report employees, the entire gro port. oxes)	orting purposes if such coup of such individua	ontracts are exp	perience-ra ch carrier n	nay	
	a ☐ Health (other than dental or vision)	b 🔀 Dental	c ☐ Vision		d 🔲	Life insuran	ce
	e ☐ Temporary disablility (accident and sickness)	f ☐ Long-term disability	g Supplementa	al unemployment	h 🔲	Prescription	drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO contrac	t	ı	Indemnity c	ontract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re				9a(1) 9a(2) 9a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))				9b(1) 9b(2)	9a(4) 9b(3)	
	(4) Claims charged					9b(4)	
С	Remainder of premium: (1) Retention charges	(on an accrual basis) -			0-(4)(4)		
	(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs				9c(1)(A) 9c(1)(B) 9c(1)(C)		
	(D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges				9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G)		
	(H) Total Retention					9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were \square paid in	cash, or \square credited.)			9c(2)	
d	Status of policyholder reserves at end of year: (2) Claim reserves (3) Other reserves	(1) Amount held to provide	e benefits after retireme	nt		9d(1) 9d(2) 9d(3)	
	Dividends or retroactive rate refunds due. (Do	not include amount entere	d in c(2).)			9è	
	Nonexperience-rated contracts Total premiums or subscription charges paid to	carrier				10a	\$110,330
	If the carrier, service, or other organization incuretention of the contract or policy, other than re Specify nature of costs below:	urred any specific costs in		uisition or		10b	ψ110,000
D:	rt IV · Provision of Information						
	Did the insurance company fail to provide any i	information necessary to c	omplete Schedule A?			☐Yes	s 🛚 No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2015 or fiscal plan year beginning December 01, 2015, and ending November 30, 2016 A Name of plan

B Three-digit plan number (PN)

501

11/30/2016

ROIG LAWYERS HEALTH AND BENEFITS

C Plan sponsor's name as shown on line 2a of Form 5500

80802

D Employer Identification Number (EIN)

ROIG LAWYERS

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

2080

SUN LIFE ASSURANCE COMPANY OF CANADA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

12/01/2015

\$18,744

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

238423

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

248

(e) Organization code

\$18,744

Balance at the end of the previous year

(3) Interest credited during the year

(4) Transferred from separate account

(2) Dividends and credits

Additions: (1) Contributions deposited during the year

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2015 v.092308.1

7b

7c(1)

7c(2)

7c(3)

7c(4)

1	l A!4	🔿 4 4	Information
investment	and Annilit	v c.ontract	intormation

Investment and Annuity Contract Information	
Part II Where individual contracts are provided, the entire group of such individual contracts with each carrier	r may be treated as a unit for
purposes of this report.	
Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5
6 Contracts With Allocated Funds	
a State the basis of premium rates	
b Premiums paid to carrier	6b
c Premiums due but unpaid at the end of the year	6c
d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount	6d
Specify nature of costs	
e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)	
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts))
a Type of contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee	
(3) augranteed investment (4) other	

3/6/	Case 1:18-cv-01805 (5) Other (specify below)	-JGK Doculmaentো	e <u>4-freq</u> ER SA 03/07/18 F	Page 27 of 91 7c(5)
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:))		7c(6) 7d
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa	ı me group of employees of t	he same employer(s) or members	7e(5) 7f s of the same
	rt III employee organization(s), the information as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable b	may be combined for report employees, the entire grou port. oxes)	ting purposes if such contracts up of such individual contracts v	are experience-rated with each carrier may
	a Health (other than dental or vision)	b Dental	c ☐ Vision	d 🗵 Life insurance
	e X Temporary disablility (accident and sickness)	f Ϫ Long-term disability	g Supplemental unemploy	ment h Prescription drug
	i ☐ Stop loss (large deductible) m ☑ Other (specify) ACCIDENTAL DEATH AN	j ☐ HMO contract ID DISMEMBERMENT	k ☐ PPO contract	I ☐ Indemnity contract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpage			9a(1) 9a(2)
	(3) Increase (decrease) in unearned premium re (4) Earned ((1)+(2)-(3))	eserve		9a(3) 9a(4)
b	Benefit charges: (1) Claims paid			9b(1)
	(2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))			9b(2) 9b(3)
	(4) Claims charged			9b(4)
С	Remainder of premium: (1) Retention charges	(on an accrual basis) -		
	(A) Commissions (B) Administrative service or other fees			9c(1)(A) 9c(1)(B)
	(C) Other specific acquisition costs			9c(1)(C)
	(D) Other expenses			9c(1)(D)
	(E) Taxes (F) Charges for risks or other contingencies			9c(1)(E) 9c(1)(F)
	(G) Other retention charges			9c(1)(G)
	(H) Total Retention			9c(1)(H)
4	(2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year:	e amounts were ∐ paid in o	cash, or L credited.)	9c(2)
u	(2) Claim reserves	(1) Amount held to provide	benefits after retirement	9d(1) 9d(2)
	(3) Other reserves			9d(3)
	Dividends or retroactive rate refunds due. (Do Nonexperience-rated contracts	not include amount entered	in c(2).)	9e
	Total premiums or subscription charges paid to	carrier		10a \$125,004
	If the carrier, service, or other organization incorretention of the contract or policy, other than respecify nature of costs below:	urred any specific costs in c		10b
_	at IV — Durantinian of late			
	rt IV · Provision of Information Did the insurance company fail to provide any	information necessary to co	mplete Schedule A?	☐ Yes 🔀 No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2015 or fiscal plan year beginning December 01, 2015, and ending November 30, 2016 A Name of plan

B Three-digit plan number (PN)

501

11/30/2016

ROIG LAWYERS HEALTH AND BENEFITS	R	ЫG	LAW	rers :	HEALT	'H AND	BENEF	ITS
----------------------------------	---	----	-----	--------	-------	--------	-------	-----

C Plan sponsor's name as shown on line 2a of Form 5500

79413

D Employer Identification Number (EIN)

ROIG LAWYERS

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

UNITEDHEALTHCARE INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

12/01/2015

\$78,805

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

903798

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 1560 SAWGRASS CORPORATE PKWY #300 SUNRISE FL 33323

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose

(e) Organization code

(c) Amount \$78,805

SERVICE FEE AGREEMENT

272

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2015 v 092308 1

as a unit for

1	I A : 4	^ 4 4	Information

purposes of this report.	
Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5
Contracts With Allocated Funds	

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated

a State the basis of premium rates

Part II

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d

or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other

Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1)

(2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/2	2018 Case 1:18-cv-01805- (5) Other (specify below)	JGK Doculnste	<mark>nttVievt-T</mark> re ⊄ER te	№ 03/07/18	Page 29 of		
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:					7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	ase annuities during y	vear .		7e(* 7e(; 7e(; 7e(2) 3)	
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the san Int III employee organization(s), the information in as a unit. Where contracts cover individual	ne group of employee nay be combined for r employees, the entire	eporting purposes	if such contracts	are experience	-rated	
8	be treated as a unit for purposes of this rep Benefit and contract type (check all applicable bo						
	a 🔀 Health (other than dental or vision)	b Dental	c ☐ Visi	on	d [Life insur	ance
	e ☐ Temporary disablility (accident and sickness)	f Long-term disab	oility g \square Sup	plemental unemp	loyment h	Prescripti	ion drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k □ PPC	O contract	ı[Indemnity	/ contract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpai (3) Increase (decrease) in unearned premium re (4) Earned ((1)+(2)-(3))				9a(1) 9a(2) 9a(3)	9a(4)	
b	Benefit charges: (1) Claims paid				9b(1)	3a(4)	
	(2) Increase (decrease) in claim reserves				9b(2)	0b/2\	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged					9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis) -	-		0-(4)(A		
	 (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes 				9c(1)(A 9c(1)(B 9c(1)(C 9c(1)(D 9c(1)(E)))	
	(F) Charges for risks or other contingencies (G) Other retention charges				9c(1)(F 9c(1)(G		
	(H) Total Retention	_			35(1)(0	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: ((2) Claim reserves(3) Other reserves	1) Amount held to pro	vide benefits after	edited.) retirement		9c(2) 9d(1) 9d(2) 9d(3)	
	Dividends or retroactive rate refunds due. (Do n Nonexperience-rated contracts	ot include amount ent	ered in c(2).)			9e	
а	Total premiums or subscription charges paid to					10a	\$1,498,203
b	If the carrier, service, or other organization incurretention of the contract or policy, other than rep Specify nature of costs below:				or	10b	
Pa	rt IV Provision of Information						
11	Did the insurance company fail to provide any ir If the answer to line 11 is "Yes," specify the infor	-	to complete Sched	dule A?			Yes 🔀 No



Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections

104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110 1210 - 0089

This Form is Open to Public Inspection

			the instructions to the Form 5				
	t I Annual Report Identification In						
A a	calendar plan year 2016 or fiscal plan multiple-employer plan (Filers checking mployer information in accordance with	g this box mus	t attach a list of participating	ebruary 28, 20 a multiemploye plan; a single- employer pla	er	☐ a multiple-en☐ a DFE (speci	
ВТ	his return/report is:			the first return/report an amer return/report	nded	the final return a short plan y return/report (less months).	/ear
C	f the plan is a collectively-bargained pla	n, check here		_			
D C	Check box if filling under:			☐ Form 55	•	☐ automatic extension;	☐ the DFVC program;
				☐ special e	extens	ion (enter descriptio	n)
Par 1a	t II · Basic Plan Information – enter Name of plan VISION GROUP HOLDINGS HEALTI					Three-digit plan number (PN) Effective date of plan March 01, 2015	501 an
2a	Plan sponsor's name and address, in plan) VISION GROUP HOLDINGS 1555 PALM BEACH LAKES BOULEV SUITE 600 WEST PALM BEACH FL 33401	-	or suite number (Employer, if for a sin	ngle-employer	2c 2d	Employer Identificat 7674 Sponsor's telephone 561-965-9110 Business code (see 446130	e number
Und sche	tion: A penalty for the late or incomplet er penalties of perjury and other penalti edules, statements and attachments, as ect, and complete.	es set forth in	the instructions, I declare that I have	examined this	returr	/report, including ac	
		09/21/2017	SHARON L. WAY	,			
•	Signature of plan administrator	Date	Enter name of individual signing as	plan administra	ator		
•	Signature of employer/plan sponsor	Date	Enter name of individual signing as sponsor	employer or p	lan		
	Signature of DFE	Date	. Enter name of individual sign	ning as DFE			
For	Paperwork Reduction Act Notice and			· ·		F	orm 5500 (2016)
3a	Plan administrator's name and address				3b 3c	Administrator's EIN Administrator's telep	v.092308.1

3/0/20	Case 1:18-cv-01805-JGK Documentury: Tientury: 03/0	7/18 Page 32	01 91
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this enter the name, EIN and the plan number from the last return/report below:		hb EIN 51-0487674 hc PN
	a Sponsor's name VISION GROUP HOLDINGS, LLC	•	501
5 6	Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year unless otherwise stated (welfare plans only samplets lines 60(4), 60(2), 656, 650, and 6d)	5 y	839
a(2) b	complete lines 6a(1) , 6a(2) , 6b , 6c , and 6d) Total active number of participants at the beginning of the plan year Total active number of participants at the end of the plan year Retired or separated participants receiving benefits	6a(1) 6a(2) 6b	512
c d e f	Other retired or separated participants entitled to future benefits Subtotal. Add lines 6a(2) , 6b , and 6c Deceased participants whose beneficiaries are receiving or are entitled to receive benefits Total. Add lines 6d and 6e	6c 6d 6e 6f	611
g h	Number of participants with account balances as of the end of the plan year (only defined contri plans complete this item) Number of participants that terminated employment during the plan year with accrued benefits to were less than 100% vested	•	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	. ,	0
8a b	If the plan provides pension benefits, enter the applicable pension feature codes from the List Characteristics Codes in the instructions: If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Characteristics Codes in the instructions: 4A 4B 4D 4E 4F 4H 4L 4Q		
(1 (2 (3 (4 10 C	lan funding arrangement (check all that apply) Insurance Section 412(e)(3) insurance contracts Trust General assets of the sponsor heck all applicable boxes in 10a and 10b to indicate which schedules are attached,and, where inductions)	(3) insurance contract	ts
	ension Schedules Description R (Retirement Plan Information) Description B General Schedules (1) H (Financial	Information)	
(2	Purchase Plan Actuarial Information)- signed by the plan actuary (3) X 3 A (Insurance (4) C (Service P	Provider Information)	·
Part 11a	- signed by the plan actuary (6) G (Financial III Form M-1 Compliance Information (to be completed by welfare benefit plans) If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during instructions and 29 CFR 2520.101-2) Yes No If "Yes" is checked, complete lines 11b and 11c.	g the plan year? (See	es)
	Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2 Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not reform M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the as incomplete.) Receipt Confirmation Code	equired to file the 2016 required to be filed un	3 nder the

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

Pension Benefit Guaranty Corporation For the calendar plan year 2016 or fiscal plan year beginning March 01, 2016, and ending February 28, 2017 A Name of plan

B Three-digit plan number (PN)

501

02/28/2017

VISION GROUP HOLDINGS HEALTH & WELFARE BENEFITS

C Plan sponsor's name as shown on line 2a of Form 5500

65978

D Employer Identification Number (EIN)

VISION GROUP HOLDINGS

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

METROPOLITAN LIFE INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in

descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

03/01/2016

1623

\$39,849 \$5,653

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

5926235

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

WELLS FARGO INSURANCE 1018 WEST 9TH AVENUE KING OF PRUSSIA PA 19406

(b) Amount of sales and base Fees and other commissions paid (e) Organization commissions paid (c) Amount (d) Purpose code

\$39,849 NON-MONETARY COMPENSATION SUPPLEMENTAL COMPENSATION \$5,653 3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v.092308.1

7c(1)

7c(2)

7c(3)

7c(4)

Investment and Annuity Contract Information Part II • Where individual contracts are provided, the entire group of such individual contracts with each carrier may be purposes of this report.	treated as a unit for
4 Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5
6 Contracts With Allocated Funds	
a State the basis of premium rates	
b Premiums paid to carrier	6b
c Premiums due but unpaid at the end of the year	6c
d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount	6d
Specify nature of costs	
e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)	
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other	
b Balance at the end of the previous year	7b

Additions: (1) Contributions deposited during the year

(2) Dividends and credits

(3) Interest credited during the year

(4) Transferred from separate account

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Doculnstent	V i⊵4-	'/18 Page 3	34 of 91 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:))				7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	hase annuities during yea	ır		7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa rt III employee organization(s), the information	ı me group of employees o	of the same employer(s) or	members of the	same	7e(5) 7f	
	as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable b	l employees, the entire gr port. oxes)	oup of such individual o			ч	
	a Health (other than dental or vision)	b X Dental	c 🔀 Vision			fe insurance	
	e ☐ Temporary disablility (accident and sickness)	f ☐ Long-term disabilit	y g ☐ Supplemental	unemployment	h ∐ Pr	escription o	Irug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO contract		I 🗌 In	demnity cor	ntract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re				9a(1) 9a(2) 9a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves					9a(4)	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged					9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges	(on an accrual basis) -				(-)	
	 (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies 			9	9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F)		
	(G) Other retention charges (H) Total Retention			`	9c(1)(G) 9	c(1)(H)	
d	(2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: (2) Claim reserves	e amounts were paid i (1) Amount held to provid	n cash, or ☐ credited.) de benefits after retirement	:		9c(2) 9d(1) 9d(2)	
е	(3) Other reserves Dividends or retroactive rate refunds due. (Do	not include amount enter	ed in c(2).)			9d(3) 9e	
10	Nonexperience-rated contracts		\				
	Total premiums or subscription charges paid to If the carrier, service, or other organization incuretention of the contract or policy, other than re Specify nature of costs below:	urred any specific costs in		isition or		10a \$ 10b	406,117
	, ,						
	rt IV · Provision of Information Did the insurance company fail to provide any i	information necessary to	complete Schedule A?			Yes	X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning March 01, 2016, and ending February 28, 2017 A Name of plan

B Three-digit plan number (PN)

501

VISION GROUP HOLDINGS HEALTH & WELFARE BENEFITS

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

VISION GROUP HOLDINGS

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

65676 10203096 925 03/01/2016 02/28/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$32,729 \$10,454

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

WELLS FARGO INSURANCE 2502 NORTH ROCKY POINT DRIVE 400 **ROCKY POINT FL 33607**

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$32,729

\$10,454

FEES

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

6d

7b

7c(4)

Investment	and An	nuity Cດ	ntract l	nformation

Part II Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. 4 Current value of plan's interest under this contract in the general account at year end 5

Current value of plan's interest under this contract in separate accounts at year end 6 Contracts With Allocated Funds

a State the basis of premium rates

(4) Transferred from separate account

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c d If the carrier, service, or other organization incurred any specific costs in connection with the acquision

or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year

Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3)

http://freeerisa.benefitspro.com/5500/formprint.aspx?DLN=20170921105907P030147487079001

3/6/	2018 Case 1:18-cv-01805- (5) Other (specify below)	JGK Doculnstentt ^v i⊵v	∤- fr ∘∉R&∂ 03/07/18 Page	36 of 91 7c(5)	_			
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:				7c(6) 7d			
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	ase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)				
f	 (5) Total deductions f Balance at the end of the current year (subtract e(5) from d) Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the 					7e(5) 7f		
	art III employee organization(s), the information n as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable bo	nay be combined for reportinemployees, the entire group ort. oxes)	g purposes if such contracts are ex of such individual contracts with ea	xperience-ra ach carrier m	nay			
		b ∐ Dental	c ☐ Vision	d 🔀 [₋ife insuran	ice		
	e X Temporary disablility (accident and sickness)	f I Long-term disability	g ☐ Supplemental unemployment	h 🔲 F	Prescription	n drug		
	i ☐ Stop loss (large deductible) m ☑ Other (specify) ACCIDENTAL DEATH AND	j ☐ HMO contract		Ι□Ι	ndemnity o	ontract		
9	Experience related contracts		0 122 70010 171102 1 1001 0 101					
а	Premiums: (1) Amount received			9a(1)				
	(2) Increase (decrease) in amount due but unpai			9a(2)				
	(3) Increase (decrease) in unearned premium re (4) Earned ((1)+(2)-(3))	serve		9a(3)	9a(4)			
b	Benefit charges: (1) Claims paid			9b(1)	3a(4)			
	(2) Increase (decrease) in claim reserves			9b(2)				
	(3) Incurred claims (add (1) and (2))				9b(3)			
_	(4) Claims charged	on an apprual basis)			9b(4)			
C	Remainder of premium: (1) Retention charges ((A) Commissions	on an accidal basis) –		9c(1)(A)				
	(B) Administrative service or other fees			9c(1)(B)				
	(C) Other specific acquisition costs			9c(1)(C)				
	(D) Other expenses			9c(1)(D)				
	(E) Taxes (F) Charges for risks or other contingencies			9c(1)(E) 9c(1)(F)				
	(G) Other retention charges			9c(1)(G)				
	(H) Total Retention		_		9c(1)(H)			
	(2) Dividends or retroactive rate refunds. (These amounts were \square paid in cash, or \square credited.)							
d	d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement				9d(1)			
	(2) Claim reserves (3) Other reserves				9d(2) 9d(3)			
е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered in	n c(2).)		9e			
	Nonexperience-rated contracts		· //					
	Total premiums or subscription charges paid to				10a	\$327,286		
b	If the carrier, service, or other organization incurretention of the contract or policy, other than rep Specify nature of costs below:				10b			
	•							
	art IV · Provision of Information		mlata Calcadala AO			. .		
11	Did the insurance company fail to provide any ir	ntormation necessary to com	piete Schedule A?		∐ Ye:	s 🔼 No		

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

Pension Benefit Guaranty Corporation For the calendar plan year 2016 or fiscal plan year beginning March 01, 2016, and ending February 28, 2017 A Name of plan

B Three-digit plan number (PN)

501

VISION GROUP HOLDINGS HEALTH & WELFARE BENEFITS

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

VISION GROUP HOLDINGS

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

AMERICAN HERITAGE LIFE INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

1901 60534 V7880 80 03/01/2016 02/28/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$4,875

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

WELLS FARGO INSURANCE PO BOX 201629 DALLAS TX 75320

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$4,875

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

6d

Investment		

Part II · Where individual contracts are provided, the entire group of such individual contracts with each carrier ma	ay be treated as a unit for
purposes of this report.	
Current value of plan's interest under this contract in the general account at year end	4
Current value of plan's interest under this contract in separate accounts at year end	5

6 Contracts With Allocated Funds

Current value of plan's interest under this contract in separate accounts at year end

a State the basis of premium rates **b** Premiums paid to carrier

6b c Premiums due but unpaid at the end of the year 6c d If the carrier, service, or other organization incurred any specific costs in connection with the acquision

or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) individual policies (2) ☐ group deferred annuity (3) ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1)

(2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Docu insen ti ^v 連	⊈ -fre ∉R& 03/07/18 Page	e 38 of 91 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)			7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa rt III employee organization(s), the information	me group of employees of th	e same employer(s) or members of th		7e(5) 7f	
	as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Ben <u>ef</u> it and contract type (check all applicable b	employees, the entire group port. oxe <u>s)</u>	of such individual contracts with e		ay	
	a Health (other than dental or vision)	b Dental	c		ife insurand	
	e Temporary disablility (accident and sickness)	f ☐ Long-term disability	g Supplemental unemployment	h ∏ F	Prescription	drug
	i ☐ Stop loss (large deductible) m ☑ Other (specify) CRITICAL ILLNESS ACCI	j ☐ HMO contract DENT	k ☐ PPO contract	I 🗌 Ir	ndemnity co	ontract
	Experience related contracts Premiums: (1) Amount received			9a(1)		
	(2) Increase (decrease) in amount due but unpa			9a(2)		
	(3) Increase (decrease) in unearned premium re (4) Earned ((1)+(2)-(3))	eserve		9a(3)	9a(4)	
b	Benefit charges: (1) Claims paid			9b(1)	Ja(4)	
	(2) Increase (decrease) in claim reserves			9b(2)		
	(3) Incurred claims (add (1) and (2))				9b(3)	
С	(4) Claims charged Remainder of premium: (1) Retention charges	(on an accrual basis) –			9b(4)	
·	(A) Commissions	(0.1. a.1. a.0 a.a. b.a.0.0)		9c(1)(A)		
	(B) Administrative service or other fees			9c(1)(B)		
	(C) Other specific acquisition costs (D) Other expenses			9c(1)(C) 9c(1)(D)		
	(E) Taxes			9c(1)(E)		
	(F) Charges for risks or other contingencies			9c(1)(F)		
	(G) Other retention charges (H) Total Retention			9c(1)(G)	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were \square paid in ca	ash or credited)	•	9c(2)	
d	Status of policyholder reserves at end of year:	(1) Amount held to provide b	enefits after retirement		9d(1)	
	(2) Claim reserves				9d(2)	
е	(3) Other reserves Dividends or retroactive rate refunds due. (Do i	not include amount entered in	n c(2).)		9d(3) 9e	
	Nonexperience-rated contracts		() /			
	Total premiums or subscription charges paid to				10a	\$25,607
a	If the carrier, service, or other organization incuretention of the contract or policy, other than re Specify nature of costs below:				10b	
_	wt IV Dunyinian of Information					
	rt IV · Provision of Information Did the insurance company fail to provide any i	nformation necessary to com	nplete Schedule A?		□Yes	X No



Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110 1210 - 0089

2016

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

For A a	t I · Annual Report Identification Incalendar plan year 2016 or fiscal plan multiple-employer plan (Filers checking employer information in accordance with	n <mark>year beginn</mark> g this box mus	t attach a list of participating		r		nployer plan; ify)
ВТ	his return/report is:			the first return/report; an amend return/report;	ded	the final retu a short plan return/report (les months).	year
C I	f the plan is a collectively-bargained pla	n, check here		return/report,		monuis).	
D (Check box if filling under:			X Form 555	58;	☐ automatic extension;	the DFVC program;
				special ex	xtens	ion (enter description	
•.	t II · Basic Plan Information – enter	all requested	information.		46	Thurs a dissit	
1a	Name of plan					Three-digit plan number (PN)	501
	INTERCONTINENTAL AT DORAL MI	AMI HEALTH	AND WELFARE PLAN	•	1c	Effective date of pl May 01, 2000	an
2a	Plan sponsor's name and address, inc	cluding room o	or suite number (Employer, if for a sing	gle-employer		Employer Identification	
	INTERCONTINENTAL AT DORAL MI 2505 NW 87TH AVE DORAL FL 33172	AMI			2d	Sponsor's telephon 305-468-1400 Business code (see 531390	
Und sche	Ition: A penalty for the late or incomplet er penalties of perjury and other penalti edules, statements and attachments, as ect, and complete.	es set forth in	the instructions, I declare that I have	examined this r	returr	n/report, including a	
		09/08/2017	ROSIE BALLESTE	₹			
•	Signature of plan administrator	Date	Enter name of individual signing as p	olan administrat	tor		
•	Signature of employer/plan sponsor	Date	Enter name of individual signing as sponsor	employer or pla	an		
•	Signature of DFE	Date	. Enter name of individual signi	ing as DFE			
For	Paperwork Reduction Act Notice and		<u> </u>	•		F	orm 5500 (2016)
3a	Plan administrator's name and addres	ss (if same as	plan sponsor, enter"Same")			Administrator's EIN Administrator's tele	v.092308.1 phone number

3/6/20	Case 1:18-cv-0180	5-JGK	Document/i	<u>M</u> - <u>T</u> redE	Red 03/07/18	Page 41 of	91
4	If the name and/or EIN of the plan sponsor	has changed	d since the last re	turn/report	filed for this plan,	4 k	EIN
	enter the name, EIN and the plan number f	rom the last i	return/report belo	W:		40	: PN
	a Sponsor's name					. 40	, FIN
5 6	Total number of participants at the beginnin Number of participants as of the end of the	plan year un		ated (welfa	ire plans only	5	169
a(2) b	complete lines 6a(1), 6a(2), 6b, 6c, and 6d 1) Total active number of participants at the be 2) Total active number of participants at the er Retired or separated participants receiving Other retired or separated participants entit	eginning of the nd of the plar benefits	n year			6a(1) 6a(2) 6b	168
c d e f	Subtotal. Add lines 6a(2) , 6b , and 6c Deceased participants whose beneficiaries Total. Add lines 6d and 6e	are receivino	g or are entitled to			6c 6d 6e 6f	171
g h	Number of participants with account balanc plans complete this item) Number of participants that terminated emp			, ,		6g 6h	
7	were less than 100% vested Enter the total number of employers obligat complete this item)	•				. 7 .	0
8a	If the plan provides pension benefits, enter Characteristics Codes in the instructions:	r the applica	ble pension featu	re codes fr	om the List of Plan		
b	If the plan provides welfare benefits, enter Characteristics Codes in the instructions: 4A 4B 4D 4E 4F 4G 4H 4L	the applicab	ole welfare feature	e codes fro	m the List of Plan		
(1 (2 (3	Plan funding arrangement (check all that appl 1) Insurance 2) Section 412(e)(3) insurance contracts 3) Trust 4) General assets of the sponsor	y)	9b	(1) Ins (2) Se (3) Tru	ction 412(e)(3) insu	rance contracts	
10 Cl instru a Po	Check all applicable boxes in 10a and 10b to in ructions) Pen <u>sio</u> n Schedules	ndicate whic		attached,ar Gen<u>er</u>al S	nd, where indicated, Schedules	, enter the numbe	r attached (See
•	 R (Retirement Plan Information) MB (Multiemployer Defined Benefit Plans 			(2)	H (Financial Inform	nation – Small Pla	ın)
(3	☐ Purchase Plan Actuarial Information)-3) ☐ SB (Single-Employer Defined Benefit I		•		A (Insurance InformC (Service ProvideD (DFE/Participatin	er Information)	on)

(3) SB (Single-Employer Defined Benefit Plan Actuarial Information)
- signed by the plan actuary

(5) D (DFE/Participating Plan Information G (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2)..... ☐ Yes No

Instructions and 29 CFR 2520.101-2)..... Larges La If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with M-1 filing requirements? (See instructions and 29 CFR 2520.101-2)...... Yes

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

INTERCONTINENTAL AT DORAL MIAMI

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

AFLAC

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

01/01/2016 12/31/2016

60380 CG420 11 2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in

descending order of the amount paid. (a) Total amount of commissions paid

(b) Total amount of fees paid

\$972

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

VARIOUS-SEE ATTACHMENT 1932 WYNNTON ROAD **COLUMBUS GA 31999**

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$972

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

7b

7c(4)

and Annuity	

Part II · Where individual contracts are provided, the entire group of such individual contracts with each ca	arrier may be treated as a unit for
purposes of this report.	
Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5

Contracts With Allocated Funds a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year Additions: (1) Contributions deposited during the year 7c(1)

(2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Docu insen tV重	4 4-1 ^{re} €R& 03/07/18 Pag	e 43 of 91 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)			7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sai		ne same emplover(s) or members of t		7e(5) 7f	
	Irt III employee organization(s), the information of as a unit. Where contracts cover individual be treated as a unit for purposes of this replaced and contract type (check all applicable benefit and contract type).	may be combined for reporti employees, the entire group oort.	ng purposes if such contracts are of such individual contracts with o	experience-rated each carrier may	/	
	a 🔀 Health (other than dental or vision)	b Dental	c ☐ Vision	d ☐ Life	e insurance	•
	e ☐ Temporary disablility (accident and sickness)	f ☐ Long-term disability	g Supplemental unemploymen	t h ∏Pre	escription d	rug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO contract	I ☐ Ind	lemnity cor	ntract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re			9a(1) 9a(2) 9a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))			9b(1) 9b(2))a(4)	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged				9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges	(on an accrual basis) –			` ,	
	(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs			9c(1)(A) 9c(1)(B) 9c(1)(C)		
	(D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (C) Other retention charges			9c(1)(D) 9c(1)(E) 9c(1)(F)		
	(G) Other retention charges (H) Total Retention			9c(1)(G) 9c	(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were \square paid in c	ash, or \square credited.)	9	c(2)	
d	Status of policyholder reserves at end of year: (2) Claim reserves (3) Other reserves	(1) Amount held to provide b	penefits after retirement	9	0d(1) 0d(2) 0d(3)	
	Dividends or retroactive rate refunds due. (Do r	not include amount entered i	n c(2).)		9è ´	
	Nonexperience-rated contracts Total premiums or subscription charges paid to	carrier			10a \$	12,184
	If the carrier, service, or other organization incuretention of the contract or policy, other than respecify nature of costs below:	irred any specific costs in co			10b	12,104
D,	rt IV · Provision of Information					
					Yes	X No

SCHEDULE A Form 5500

Department of the Treasury Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor
Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

B Three

B Three-digit plan number (PN)

501

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

INTERCONTINENTAL AT DORAL MIAMI

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

AMERICAN PUBLIC LIFE INSURANCE COMPANY

(b) EIN (c) NAIC code

(d) Contract or identification number

(e) Aproximate number of persons covered at end of policy or contract year Policy or contract year

(f) From

(g) To

9942

60801

APSB22134

49

01/01/2016

12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$3,744

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

THE SOUTHERN REGION LLC 6151 LAKE OSPREY DR, 3RD FLOOR SARASOTA FL 34240

(b) Amount of sales and base commissions paid

Fees and other commissions paid (c) Amount (d) Purpose

(e) Organization code

\$2,081

3

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (c) Amount (d) Purpose

(e) Organization code

\$1,663

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

Investment and Annuity Contract Information

Part II · Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end

4 5

5 Current value of plan's interest under this contract in separate accounts at year end

Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier

6b

c Premiums due but unpaid at the end of the year

6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision

6d

3/6/2018 Case 1:18-cv-01805-JGK Documstant/124-freeFREA 03/07/18 Page 45 of 91 or retention of the contract or policy, enter amount Specify nature of costs (2) group deferred annuity (3) other (specify) e Type of contract (1) ☐ individual policies f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) quaranteed investment (4) other **b** Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4) (5) Other (specify below) 7c(5) (6) Total additions 7c(6) Total of balance and additions (add **b** and **c** (6)) 7d Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year 7e(1) (2) Administration charge made by carrier 7e(2) (3) Transferred to separate account 7e(3) (4) Other (specify below) 7e(4) (5) Total deductions 7e(5) Balance at the end of the current year (subtract e(5) from d) **Welfare Benefit Contract Information** If more than one contract covers the same group of employees of the same employer(s) or members of the Part III employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. Benefit and contract type (check all applicable boxes) c Vision d Life insurance **a** Kealth (other than dental or vision) **b** Dental e Temporary disablility **f** ☐ Long-term disability g

Supplemental unemployment **h** Prescription drug (accident and sickness) k ☐ PPO contract Stop loss (large deductible) j HMO contract I Indemnity contract m Other (specify) Experience related contracts Premiums: (1) Amount received 9a(1) (2) Increase (decrease) in amount due but unpaid 9a(2) (3) Increase (decrease) in unearned premium reserve 9a(3) (4) Earned ((1)+(2)-(3)) 9a(4) Benefit charges: (1) Claims paid 9b(1) (2) Increase (decrease) in claim reserves 9b(2) (3) Incurred claims (add (1) and (2)) 9b(3) (4) Claims charged 9b(4) Remainder of premium: (1) Retention charges (on an accrual basis) -(A) Commissions 9c(1)(A) 9c(1)(B) (B) Administrative service or other fees 9c(1)(C) (C) Other specific acquisition costs 9c(1)(D) (D) Other expenses (E) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F) (G) Other retention charges 9c(1)(G) (H) Total Retention 9c(1)(H) (2) Dividends or retroactive rate refunds. (These amounts were \square paid in cash, or \square credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts Total premiums or subscription charges paid to carrier \$20,822 10a If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, item 2 above, report amount Specify nature of costs below: Part IV Provision of Information Yes X No 11 Did the insurance company fail to provide any information necessary to complete Schedule A? 12 If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

INTERCONTINENTAL AT DORAL MIAMI

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

Part II

(a) Name of insurance carrier

COVENTRY HEALTH CARE OF FLORIDA, INC.

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 9885280000 95114 165 01/01/2016 12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$42,043

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$42,043

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

as a unit for

Investment and Annuity Contract Info	ormation		
Where individual contracts are provided	d, the entire group of such individual conti	tracts with each carrier	may be treated

	purposes of this report.		
4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	
6	Contracts With Allocated Funds		
	a State the basis of promium rates		

State the basis of premium rates **b** Premiums paid to carrier

6b c Premiums due but unpaid at the end of the year 6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

(Contracts With Una	allocated Funds (Do not include porti	ons of these co	ontracts maintained	d in separate	accounts)
а	Type of contract	(1) deposit ad	ministration (2)	immediate pa	articipation guarant	tee	•

	(3) ☐ guaranteed investment (4) ☐ other	
b	Balance at the end of the previous year	71
С	: Additions: (1) Contributions deposited during the year	7c(1)
	(2) Dividends and credits	7c(2)

(3) Interest credited during the year (4) Transferred from separate account

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Doculn	9ent (V 124 -1	Fre 4=R&A 03/07/18	•	of 91 7c(5)	
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)				7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuities durin	g year			7e(1) 7e(2) 7e(3) 7e(4)	
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa	me group of employ	ees of the s	ame employer(s) or memb	ers of the s	7e(5) 7f	
	irt III employee organization(s), the information as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable b	may be combined for employees, the ent port.	or reporting p	ourposes if such contracts	are experie	arrier may	
	a 🔀 Health (other than dental or vision)	b Dental		c ☐ Vision		d Life insura	nce
	e ☐ Temporary disablility (accident and sickness)	f ☐ Long-term dis	sability	g \square Supplemental unempl	oyment	h Prescription	n drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j <mark>Ϫ</mark> HMO contrac	t	k ☐ PPO contract		I ☐ Indemnity	contract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re				9a	n(1) n(2) n(3)	
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves				9b	9a(4) 9(1) 9(2)	
	(3) Incurred claims (add (1) and (2))					9b(3)	
С	(4) Claims charged Remainder of premium: (1) Retention charges	(on an accrual basis	s) —			9b(4)	
	(A) Commissions(B) Administrative service or other fees	`	•		9c(1	1)(A) 1)(B)	
	(C) Other specific acquisition costs(D) Other expenses(E) Taxes(F) Charges for risks or other contingencies				9c(1 9c(1	1)(C) 1)(D) 1)(E) 1)(F)	
	(G) Other retention charges (H) Total Retention				9c(1	I)(G)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were \Box	paid in cash	or credited.)		9c(1)(H) 9c(2)	
d	Status of policyholder reserves at end of year: (2) Claim reserves	(1) Amount held to	provide bene	efits after retirement		9d(1) 9d(2)	
e	(3) Other reserves Dividends or retroactive rate refunds due. (Do	not include amount	entered in c	(2))		9d(3) 9e	
	Nonexperience-rated contracts	not molade amount		(~).)		00	
	Total premiums or subscription charges paid to		oto in conn	action with the acquisition o	r	10a	\$700,381
D	If the carrier, service, or other organization incorretention of the contract or policy, other than re Specify nature of costs below:				''	10b	
Pa	rt IV Provision of Information						
	Did the insurance company fail to provide any	nformation necessa	ry to comple	ete Schedule A?		□Ye	es 🔀 No

- Did the insurance company fail to provide any information necessary to complete Schedule A?If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210 - 0110

This Form is Open to Public Inspection

	fits Security Administration ofit Guaranty Corporation		ERISA section 103(a)(2).		
			01, 2016, and ending December 31	, 2016	
A Name of plan			_	B Three-digit	
INTERCONTINE	ENTAL AT DORAL MIAN	II HEALTH AND WELFARE PLAN	N	plan number (PN)	501
C Plan sponsor's r	name as shown on line 2	a of Form 5500		D Employer Identificat	ion Number (EIN)
INTERCONTINE	ENTAL AT DORAL MIAN	11		2710	
	parate Schedule Ā. Indiv nation		and Commissions.Provide information Parts II and III can be reported or		
		FIDELITY SECURITY LIF	E INSURANCE COMPANY		
		(d) Contract or	(e) Aproximate number of	Policy or co	ntract vear
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	(g) To
9844	71870	9811431	89	01/01/2016	12/31/2016
		on. Enter the total fees and total c	commissions paid. List in item 3 the a	agents, brokers, and oth	ner persons in
descending order	of the amount paid. (a) Total amount of com	missions paid	(b) Total am	ount of fees paid	
	\$556				
3 Persons receiving	ng commissions and fee	s. (Complete as many entries as	needed to report all persons).		
	(a) Name and ac	ddress of the agent, broker or oth	er person to whom commissions or	fees were paid	
		4565 PAYSPI	AND BENEFITS, LLC HERE CIRCLE O IL 60674		
(b) Ai	mount of sales and base commissions paid	Fees (c) Amoun	and other commissions paid it (d) Purpose		anization ode
	\$556				<u>3</u>
For Paperwork Ro	eduction Act Notice an	d OMB Control Numbers, see t	he instructions for Form 5500.	Schedule A (F	Form 5500) 2016 v.092308.1
Part II Where	ment and Annuity Cont individual contracts are of this report.		h individual contracts with each carri	er may be treated a	s a unit for
4 Current value of	f plan's interest under thi	s contract in the general account			4
5 Current value of6 Contracts With		s contract in separate accounts a	it year end		5
a State the basis	s of premium rates				
b Premiums paid	d to carrier but unpaid at the end of	the year			Sb Sc
		tion incurred any specific costs in	connection with the acquision		3d 3d
or retention of Specify nature	the contract or policy, en	ter amount		`	Ju
	ct (1) individual policie	es (2) group deferred annu	ity (3) other (specify)		
f If contract pure	chased, in whole or in pa	rt, to distribute benefits from a ter	· · · · · · · · · · · · · · · · · · ·	te)	
	ct (1) 🔲 deposit admini	stration (2) immediate particle restment (4) other		,	
b Balance at the	guaranteed inv نے (3) e end of the previous yea			7	7b
c Additions: (1)	Contributions deposited			7c(1)	
(2) Dividends a	and credits edited during the year			7c(2) 7c(3)	

(4) Transferred from separate account

7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Doculnite	ነ ተቲ√ ፻⊻- 1re ⊄=R&∂ 03	3/07/18 Page 4	19 of 91 7c(5)	
	(6) Total additions Total of balance and additions (add b and c (6 Deductions:))			7c(6 7d)
G	(1) Disbursed from fund to pay benefits or purc (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below)	hase annuities during y	/ear		7e(1) 7e(2) 7e(3) 7e(4)	
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa	1	s of the same employer	(s) or members of the	7e(5 7f same)
	art III employee organization(s), the information as a unit. Where contracts cover individua be treated as a unit for purposes of this re Benefit and contract type (check all applicable by	may be combined for i l employees, the entire port.	eporting purposes if suc	h contracts are exp	erience-rated	
	a ☐ Health (other than dental or vision)	b Dental	c 🔀 Vision		d ☐ Life inst	ırance
	e ☐ Temporary disablility	f ☐ Long-term disal	oility g \square Suppleme	ental unemployment	h ☐ Prescrip	otion drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO conti	· · ·	I ☐ Indemn	•
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpotential (3) Increase (decrease) in unearned premium relations.				9a(1) 9a(2) 9a(3)	
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))				9a(4) 9b(1) 9b(2) 9b(3)	
С	(4) Claims chargedRemainder of premium: (1) Retention charges	(on an accrual basis) -	_		9b(4)	
	 (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges 	,		9	9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G)	
d	(H) Total Retention (2) Dividends or retroactive rate refunds. (Thes Status of policyholder reserves at end of year: (2) Claim reserves			l.)	9c(1)(F 9c(2) 9d(1) 9d(2)	I)
	(3) Other reserves Dividends or retroactive rate refunds due. (Do Nonexperience-rated contracts	not include amount en	tered in c(2).)		9d(3) 9e	
а	Total premiums or subscription charges paid to If the carrier, service, or other organization incoretention of the contract or policy, other than re Specify nature of costs below:	urred any specific cost		acquisition or	10a 10b	\$5,262
Pa	art IV · Provision of Information					
	Did the insurance company fail to provide any	information necessary	to complete Schedule A	?		Yes 🔀 No

SCHEDULE A Form 5500

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

OMB No. 1210 - 0110

This Form is Open to Public

Employee Benefi	its Security Administration its Guaranty Corporation		re required to provide the information ERISA section 103(a)(2).	n Ins	pection
		lan year beginning <mark>January</mark> (01, 2016, and ending December 31	1, 2016	
A Name of plan				B Three-digit	
INTERCONTINE	ENTAL AT DORAL MIAMI H	HEALTH AND WELFARE PLAN	N	plan number (PN)	501
C Plan sponsor's n	ame as shown on line 2a o	of Form 5500		D Employer Identifica	ation Number (EII
INTERCONTINE	ENTAL AT DORAL MIAMI			2710	
	parate Schedule Ā. Individu nation		and Commissions.Provide information Parts II and III can be reported or		
		PRE-PAID LEGAL SERVICE	ES, INC. DBA LEGALSHIELD		
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or o	contract year (g) To
6728	00000	44350	1	01/01/2016	12/31/2016
descending order of	of the amount paid.		commissions paid. List in item 3 the a		other persons in
	(a) Total amount of commi	ssions paid	(b) Iotal an	nount of fees paid	
	\$32				
3 Persons receiving	•	Complete as many entries as ess of the agent, broker or oth	needed to report all persons). er person to whom commissions or	fees were paid	
		751 WF	CAMEJO REN AVE NGS FL 33166		
` '	nount of sales and base commissions paid	Fees (c) Amoun	and other commissions paid t (d) Purpose	(e) <u>O</u>	rganization code
	\$32				<u>4</u>
For Paperwork Re	eduction Act Notice and (OMB Control Numbers, see t	he instructions for Form 5500.	Schedule A	(Form 5500) 201 v.092308
Part II Where	ment and Annuity Contra individual contracts are pro of this report.		h individual contracts with each carr	ier may be treated	as a unit for
4 Current value of5 Current value of6 Contracts With A	plan's interest under this o plan's interest under this o Allocated Funds	ontract in the general account contract in separate accounts a			4 5
a State the basisb Premiums paidc Premiums due		o voar			6b 6c
d If the carrier, se	ervice, or other organizatio the contract or policy, enter	n incurred any specific costs in	connection with the acquision		6d
e Type of contrac	ct (1) individual policies	(2) ☐ group deferred annu	· · · · · · · · · · · · · · · · · · ·		
7 Contracts With U	Jnallocated Funds (Do not ^{ct} (1) ☐ deposit administr	ation (2) 🔲 immediate partic	acts maintained in separate accoun	ts)	
h Balance at the	(3)	tment (4) ∟ other			7h

c Additions: (1) Contributions deposited during the year

(2) Dividends and credits

(3) Interest credited during the year

(4) Transferred from separate account

7c(1)

7c(2)

7c(3)

7c(4)

3/6/	2018 Case 1:18-cv-01805- (5) Other (specify below)	JGK Docu nsen ti√i⊵4	!-1 ^{re} €R& 03/07/18 Page	51 of 91 7c(5)	
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:	1		7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	ase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)	
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the san		e same employer(s) or members of the	7e(5) 7f	
	art III employee organization(s), the information n as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable bo	nay be combined for reportin employees, the entire group ort.	g purposes if such contracts are ex of such individual contracts with ea	xperience-rated ach carrier may	
	_ \	b Dental	c	d Life insuran	ce
	e ☐ Temporary disablility (accident and sickness)	f ☐ Long-term disability	g ☐ Supplemental unemployment	h Prescription	drug
	i ☐ Stop loss (large deductible) m ☑ Other (specify) LEGAL SERVICES PLAN	j ☐ HMO contract MEMBERSHIPS	k ☐ PPO contract	I ☐ Indemnity o	ontract
	Experience related contracts Premiums: (1) Amount received (2) Ingresse (decrease) in amount due but upper	id		9a(1)	
	(2) Increase (decrease) in amount due but unpai(3) Increase (decrease) in unearned premium re			9a(2) 9a(3)	
	(4) Earned ((1)+(2)-(3))			9a(4)	
b	Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves			9b(1) 9b(2)	
	(3) Incurred claims (add (1) and (2))			9b(3)	
_	(4) Claims charged	hi-)		9b(4)	
C	Remainder of premium: (1) Retention charges ((A) Commissions	on an accidal basis) –		9c(1)(A)	
	(B) Administrative service or other fees			9c(1)(B)	
	(C) Other specific acquisition costs (D) Other expenses			9c(1)(C) 9c(1)(D)	
	(E) Taxes			9c(1)(E)	
	(F) Charges for risks or other contingencies			9c(1)(F)	
	(G) Other retention charges (H) Total Retention			9c(1)(G) 9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in car	sh, or Credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide be	enefits after retirement	9d(1)	
	(2) Claim reserves (3) Other reserves			9d(2) 9d(3)	
е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered in	ı c(2).)	9e	
	Nonexperience-rated contracts			40-	#007
	Total premiums or subscription charges paid to If the carrier, service, or other organization incu		nnection with the acquisition or	10a	\$207
	retention of the contract or policy, other than rep Specify nature of costs below:			10b	
Pa	art IV · Provision of Information				
	Did the insurance company fail to provide any ir	nformation necessary to com	plete Schedule A?	□Ye	s 🔀 No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

INTERCONTINENTAL AT DORAL MIAMI

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

Part I

(a) Name of insurance carrier

SOLSTICE BENEFITS, INC

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 12341 98 130 01/01/2016 12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$2,662

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$2,662

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

as a unit for

Investment and Annuity Contract Information
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated

	purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds	
í	a State the basis of premium rates	
	b Premiums paid to carrier	6b

c Premiums due but unpaid at the end of the year 6с d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) individual policies (2) ☐ group deferred annuity (3) ☐ other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee

	(3) \square guaranteed investment (4) \square other		
b	Balance at the end of the previous year		7b
С	Additions: (1) Contributions deposited during the year	7c(1)	

(2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/2	2018 Case 1:18-cv-01805- (5) Other (specify below)	-JGK	Doculnstent(View-	Fred ERE 03/07/18	Page 5	53 of 93 7c(5)	L	
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)					7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annu	ities during year			7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sar rt III employee organization(s), the information r as a unit. Where contracts cover individual	me group may be co employee	of employees of the ombined for reporting	purposes if such contracts	are exp	same erience-ra h carrier n		
8	be treated as a unit for purposes of this rep Benefit and contract type (check all applicable bo							
	a ☐ Health (other than dental or vision)	b 🔀 Der	ntal	c Vision		d 🗌	Life insuranc	е
	e ☐ Temporary disablility (accident and sickness)	f 🗌 Lor	g-term disability	g Supplemental unemp	loyment	h 🗌	Prescription of	drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j□HM	O contract	k ☐ PPO contract		Ι	Indemnity co	ntract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re (4) Earned ((1)+(2)-(3))					9a(1) 9a(2) 9a(3)	9a(4)	
b	Benefit charges: (1) Claims paid					9b(1)	3a(4)	
	(2) Increase (decrease) in claim reserves					9b(2)	0h/2\	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged						9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges (on an ac	crual basis) –			2=/4\/A\		
	 (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes 				<u> </u>	9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E)		
	(F) Charges for risks or other contingencies (G) Other retention charges					9c(1)(F) 9c(1)(G)		
	(H) Total Retention		_	_	•) (i) (G)	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year:(2) Claim reserves(3) Other reserves	(1) Amoui	nt held to provide ber	nefits after retirement			9c(2) 9d(1) 9d(2) 9d(3)	
	Dividends or retroactive rate refunds due. (Do r Nonexperience-rated contracts	not include	e amount entered in	c(2).)			9e	
а	Total premiums or subscription charges paid to						10a	\$20,989
b	If the carrier, service, or other organization incuretention of the contract or policy, other than represent patterns of costs below:				or		10b	
Pa	rt IV · Provision of Information							
11	Did the insurance company fail to provide any in If the answer to line 11 is "Yes," specify the info			lete Schedule A?			Yes	X No

SCHEDULE A Form 5500

Department of the Treasury Internal Revenue Service

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

OMB No. 1210 - 0110

Employee Benef	ntment of Labor fits Security Administration fit Guaranty Corporation		es are required to provide the informati it to ERISA section 103(a)(2).		Inspection			
		plan year beginning Janua	ary 01, 2016, and ending December 3	31, 2016 B Three-digit plan number (PN)				
INTERCONTINE	ENTAL AT DORAL MIAM	I HEALTH AND WELFARE P	LAN	plan number (PN)	501			
C Plan sponsor's r	name as shown on line 2	a of Form 5500		D Employer Identific	cation Number (EIN)			
INTERCONTINE	ENTAL AT DORAL MIAM	I		2710				
Part I · Informa on a sep 1 Coverage Inform (a) Name of insura	parate Schedule Ā. Indivi nation	nnce Contract Coverage, Fe dual contracts grouped as a r	ees, and Commissions.Provide informunit in Parts II and III can be reported o	nation for each contrac on a single Schedule A	ct A.			
		UNUM LIFE INSURAN	NCE COMPANY OF AMERICA					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Aproximate number of persons covered at end of policy or contract year	Policy or (f) From	contract year (g) To			
8678	62235	632039	148	01/01/2016	12/31/2016			
2 Insurance fee an	nd commission informatio	n. Enter the total fees and tot	tal commissions paid. List in item 3 the	agents, brokers, and	other persons in			
	of the amount paid. (a) Total amount of com			mount of fees paid				
	• •	missions paid	(b) Iotal a	·				
	\$597			\$75				
3 Persons receiving			as needed to report all persons). other person to whom commissions of	r fees were paid				
		4565 PAY	TH AND BENEFITS, LLC SPHERE CIRCLE AGO IL 60674					
	unt of sales and base mmissions paid	Fe (c) Amount	es and other commissions paid (d) Purpose	(e)	Organization code			
	\$597	\$75	ADDITIONAL COMPENSATIO	N	<u>3</u>			
For Paperwork Ro	eduction Act Notice and	d OMB Control Numbers, se	ee the instructions for Form 5500.	Schedule A	(Form 5500) 2016 v.092308.1			
Part II · Where	ment and Annuity Cont individual contracts are of this report.	ract Information provided, the entire group of	such individual contracts with each car	rier may be treated	as a unit for			
4 Current value of	f plan's interest under this	s contract in the general acco			4 5			
6 Contracts With	Allocated Funds	s contract in Separate accoun	is at year end		3			
a State the basisb Premiums paid	s of premium rates d to carrier				6b			
	but unpaid at the end of		ts in connection with the acquision		6c			
or retention of	the contract or policy, en		is in connection with the acquision		6d			
Specify nature of contract	of costs ct (1)	es (2) aroup deferred a	nnuity (3) other (specify)					
f If contract pure	chased, in whole or in pa	rt, to distribute benefits from a	a terminating plan check here					
7 Contracts With U		ot include por <u>tio</u> ns of these c	ontracts maintained in separate accou	nts)				
a Type of Contract	(1) deposit adminis		articipation guarantee					

b Balance at the end of the previous year

(3) Interest credited during the year

(4) Transferred from separate account

(2) Dividends and credits

Additions: (1) Contributions deposited during the year

7b

7c(1)

7c(2)

7c(3)

7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK D	Oculnalentiview	-fre ∉R&∂ 03/07/18	Page 55	of 91 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)					7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuiti	es during year			7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa art III employee organization(s), the information	me group of	f employees of the	same employer(s) or memb	ers of the are exper	same	7e(5) 7f	
	as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable b	employees ort. oxes)	, the entire group	of such individual contrac		carrier m	ay	
	a Health (other than dental or vision)	b ☐ Denta		c ☐ Vision			ife insuranc	
	e(accident and sickness)		term disability	g Supplemental unemp	loyment		Prescription of	-
	i ☐ Stop loss (large deductible) m ☑ Other (specify) ACCIDENTAL DEATH AN	j □ HMO D DISMEMI		k ☐ PPO contract		I 🔲 II	ndemnity co	ntract
	Experience related contracts							
а	Premiums: (1) Amount received	لدن				9a(1)		
	(2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re					9a(2) 9a(3)		
	(4) Earned ((1)+(2)-(3))	2301 40			•	<i>(</i> 0)	9a(4)	
b	Benefit charges: (1) Claims paid				9	b(1)	` ,	
	(2) Increase (decrease) in claim reserves				9	b(2)	OL (O)	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged						9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges	on an accru	ual basis) –				3D(4)	
	(A) Commissions	`	,		9c	(1)(A)		
	(B) Administrative service or other fees					(1)(B)		
	(C) Other specific acquisition costs (D) Other expenses					:(1)(C) :(1)(D)		
	(E) Taxes					:(1)(E)		
	(F) Charges for risks or other contingencies					:(1)(F)		
	(G) Other retention charges				9c	(1)(G)	• 40.40	
	(H) Total Retention		🗆			,	9c(1)(H)	
Ч	(2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year:	e amounts w (1) Amount	vere ∟ paid in cas held to provide be	n, or ∟ credited.) nefits after retirement			9c(2) 9d(1)	
-	(2) Claim reserves	(1)7 111104111	noid to provide be	none and remember			9d(2)	
	(3) Other reserves						9d(3)	
	Dividends or retroactive rate refunds due. (Do	not include a	amount entered in	c(2).)			9e	
	Nonexperience-rated contracts Total premiums or subscription charges paid to	carrier					10a	\$6,462
	If the carrier, service, or other organization incu	ırred any sp			or		10b	,
	retention of the contract or policy, other than re Specify nature of costs below:	ported in Pa	art I, item 2 above,	report amount			100	
Pa	art IV · Provision of Information							
	Did the insurance company fail to provide any i	nformation i	necessary to comp	olete Schedule A?			Yes	🔀 No

SCHEDULE A Form 5500

Department of the Treasury Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor
Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110 2016

2016

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016

A Name of plan

B Three

B Three-digit plan number (PN)

501

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

INTERCONTINENTAL AT DORAL MIAMI

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

UNUM LIFE INSURANCE COMPANY OF AMERICA

(b) EIN (c) NAIC code (d) Contract or identification number (e) Aproximate number of persons covered at end of policy or contract year (f) From (g) To

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$648 \$81

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFTIS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

(c) Amount

Fees and other commissions paid (d) Purpose

(e) <u>Organization</u> <u>code</u>

\$648

\$81

ADDITIONAL COMPENSATION

Schedule A (Form 5500) 2016 v 092308 1

For P	aperwork	Reduction A	Act Notice an	d OMB	Control	Numbers,	see the	instructions	for Form	5500.

Investment and Annuity Contract Information

Part II • Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end
5 Current value of plan's interest under this contract in separate accounts at year end
6 Contracts With Allocated Funds
a State the basis of premium rates

b Premiums paid to carrier
 c Premiums due but unpaid at the end of the year
 d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount

Specify nature of costs

e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)
 a Type of contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) guaranteed investment (4) other

b Balance at the end of the previous year

c Additions: (1) Contributions deposited during the year

7c(1)

(2) Dividends and credits
(3) Interest credited during the year
(4) Transferred from separate account

7c(2)
7c(3)
7c(4)

/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Doculn¶	entt√iewt-TredERLSA	03/07/18 Page	57 of 91 7c(5)		
	 (6) Total additions Total of balance and additions (add b and c (6) Deductions: (1) Disbursed from fund to pay benefits or purch (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below) 		year			c(6) 7d	
Pa	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sal art III employee organization(s), the information is as a unit. Where contracts cover individual be treated as a unit for purposes of this rep	me group of employe may be combined for employees, the entir port.	reporting purposes if	such contracts are ex	same perience-rated	e(5) 7f	
0	Benefit and contract type (check all applicable be a \square Health (other than dental or vision)	b Dental	c ☐ Vision	1	d ☐ Life i	nsurance	•
	e(accident and sickness)	f ☐ Long-term disa		emental unemployment	h Pres		
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract		· · · · · ·	I ☐ Inde		•
а	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re (4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))				9b(1) 9b(2) 9b	(4)	
С	 (4) Claims charged Remainder of premium: (1) Retention charges (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges (H) Total Retention 	(on an accrual basis)	-		9b 9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G)	(4) ()(H)	
e	 (2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: (2) Claim reserves (3) Other reserves Dividends or retroactive rate refunds due. (Do retroactive rate refunds due.) 	(1) Amount held to p	rovide benefits after re		9c 9d 9d 9d	(2) (1) (2) (3)	
	Nonexperience-rated contracts Total premiums or subscription charges paid to If the carrier, service, or other organization incuretention of the contract or policy, other than re Specify nature of costs below:	irred any specific cos				Da S	\$7,018
Pa	art IV · Provision of Information						
	Did the insurance company fail to provide any i	nformation necessar	y to complete Schedul	ie A?		Yes	X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

01/01/2016

501

12/31/2016

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

62235

D Employer Identification Number (EIN)

INTERCONTINENTAL AT DORAL MIAMI

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

UNUM LIFE INSURANCE COMPANY OF AMERICA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$1,224 \$102

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

632041

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

(c) Amount

Fees and other commissions paid (d) Purpose

(e) Organization code

3

v 092308 1

Schedule A (Form 5500) 2016

\$1,224

(2) Dividends and credits

(3) Interest credited during the year

(4) Transferred from separate account

\$102

ADDITIONAL COMPENSATION

7c(2)

7c(3)

7c(4)

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for

Part II purposes of this report. 4 Current value of plan's interest under this contract in the general account at year end Current value of plan's interest under this contract in separate accounts at year end 5 Contracts With Allocated Funds a State the basis of premium rates **b** Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount Specify nature of costs **e** Type of contract (1) individual policies (2) group deferred annuity (3) other (specify) f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) deposit administration (2) immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1)

3/6/	2018 Case 1:18-cv-01805- (5) Other (specify below)	JGK Docu inster it ^v ⊉4	-fre ∉R&d 03/07/18 Page	59 of 91 7c(5)	L	
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:				7c(6) 7d	
	 (1) Disbursed from fund to pay benefits or purcha (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below) 	ase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract of the welfare Benefit Contract Information of the current year (subtract of the welfare Benefit Contract Information of the welfare Benefit Contract covers the same of the welfare of the we	ne group of employees of the nay be combined for reporting	g purposes if such contracts are ex	kperience-ra		
8	as a unit. Where contracts cover individual e be treated as a unit for purposes of this repo Benefit and contract type (check all applicable box	ort.	oi sucri - individual contracts with ea	ich camern	ау	
Ū		b Dental	c ☐ Vision	d 🔀 I	Life insurance	е
	e Caccident and sickness)	f ☐ Long-term disability	g Supplemental unemployment		Prescription o	-
	i ☐ Stop loss (large deductible) m ☑ Other (specify) ACCIDENTAL DEATH AND	j ☐ HMO contract DISMEMBERMENT	k ☐ PPO contract	Ι	Indemnity cor	ntract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpaid (3) Increase (decrease) in unearned premium res			9a(1) 9a(2) 9a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid			9b(1)	9a(4)	
	(2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))			9b(2)	9b(3)	
С	(4) Claims charged Remainder of premium: (1) Retention charges (c	on an accrual basis) –			9b(4)	
	(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses			9c(1)(A) 9c(1)(B) 9c(1)(C) 9c(1)(D)		
	(E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges (H) Total Retention			9c(1)(E) 9c(1)(F) 9c(1)(G)	00/4)/[]\	
	 (2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: (*) (2) Claim reserves (3) Other reserves 	Amount held to provide be	nefits after retirement		9c(1)(H) 9c(2) 9d(1) 9d(2) 9d(3)	
	Dividends or retroactive rate refunds due. (Do no Nonexperience-rated contracts	ot include amount entered in	c(2).)		9e	
а	Total premiums or subscription charges paid to of the carrier, service, or other organization incur retention of the contract or policy, other than rep Specify nature of costs below:	red any specific costs in con			10a 10b	\$8,904
Da	art IV Provision of Information					
11	Did the insurance company fail to provide any in If the answer to line 11 is "Yes," specify the infor		olete Schedule A?		Yes	X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

INTERCONTINENTAL AT DORAL MIAMI HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

INTERCONTINENTAL AT DORAL MIAMI

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

UNUM LIFE INSURANCE COMPANY OF AMERICA

(e) Aproximate number of Policy or contract year (d) Contract or persons covered at end of (b) EIN (c) NAIC code identification number (f) From (q) To policy or contract year 62235 632141 01/01/2016 12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$235 \$20

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

(c) Amount

Fees and other commissions paid (d) Purpose

(e) Organization code

ADDITIONAL COMPENSATION \$235 \$20

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

1	and Annuit	. ^ 4 4	1 £ 4!
INVASTMANT	ana Anniiit	/ Contract	Intormation

Part II	I — where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated	as a unit for
	purposes of this report.	
4 Curr	rent value of plan's interest under this contract in the general account at year end	4
5 Curr	rent value of plan's interest under this contract in separate accounts at year end	5

6 Contracts With Allocated Funds a State the basis of premium rates **b** Premiums paid to carrier 6b

c Premiums due but unpaid at the end of the year 6c If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount

Specify nature of costs **e** Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1)

(2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Docu¶1	\$@MtVi£44 -£r	e∉R&4 03/07/18	_	of 91 7c(5)	
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:))				7c(6) 7d	
·	(1) Disbursed from fund to pay benefits or purc (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below)	hase annuities durin	g year		7	7e(1) 7e(2) 7e(3) 7e(4)	
f	(5) Total deductions Balance at the end of the current year (subtrace Welfare Benefit Contract Information If more than one contract covers the sa	1	roos of the corr	me empleyer(e) er membe	ore of the	7e(5) 7f	
	rt III employee organization(s), the information as a unit. Where contracts cover individua be treated as a unit for purposes of this re Benefit and contract type (check all applicable b	may be combined for l employees, the ento port.	or reporting pu	irposes if such contracts	are experie		
Ü	$\mathbf{a} \square$ Health (other than dental or vision)	b Dental	С	Vision		d Life insurar	ice
	Temporary disablility	f Long-term dis	sahility a	Supplemental unemp	lovment	h Prescription	
	(accident and sickness) i ☐ Stop loss (large deductible)	j HMO contrac		PPO contract	ioyinon:	I ☐ Indemnity of	•
	m Stop loss (large deductible) M Other (specify) EMPLOYEE ASSISTANCE		ı ĸ	PPO contract		i 🗀 indeminity d	Ontract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unp. (3) Increase (decrease) in unearned premium r (4) Earned ((1)+(2)-(3))				9a 9a 9a	(2)	
b	Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))				9b 9b	(1) (2) 9b(3)	
С	(4) Claims charged Remainder of premium: (1) Retention charges	(on an accrual basis	s) –			9b(4)	
	 (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges 				9c(1 9c(1 9c(1 9c(1 9c(1 9c(1 9c(1)(B))(C))(D))(E))(F)	
	(H) Total Retention (2) Dividends or retroactive rate refunds. (Thes Status of policyholder reserves at end of year: (2) Claim reserves (3) Other reserves Dividends or retroactive rate refunds due. (Do	(1) Amount held to	provide benefi	its after retirement		9c(1)(H) 9c(2) 9d(1) 9d(2) 9d(3) 9e	
10	Nonexperience-rated contracts		•	, ,			
	Total premiums or subscription charges paid to If the carrier, service, or other organization inc retention of the contract or policy, other than re Specify nature of costs below:	urred any specific co	osts in connec n 2 above, rep	tion with the acquisition coort amount	or	10a 10b	\$1,728
Pa	rt IV · Provision of Information						
	Did the insurance company fail to provide any	information necessa	ry to complete	e Schedule A?		□Ye	s 🔀 No



Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections

104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

OMB Nos. 1210 - 0110 1210 - 0089

This Form is Open to Public Inspection

Complete all entries in accordance with

			the instructions to the Form 55	500.		
	t I Annual Report Identification In					
	calendar plan year 2016 or fiscal plan				_	
	multiple-employer plan (Filers checking mployer information in accordance with			□ a multiemploye plan; □ a single-employer plan	er 🔲 a DFE (s	e-employer plan; pecify)
					•••	
ВТ	his return/report is:			the first return/report; an amenoreturn/report;	a short p ded return/report	return/report; lan year (less than 12
C If	the plan is a collectively-bargained plan	n, check here				
D C	theck box if filling under:			Form 555	58; automati extension;	
				☐ special e	extension (enter descr	program; iption)
Par	t II · Basic Plan Information – enter	all requested	information.	_ '	•	' '
1a	Name of plan				1b Three-digit	501
	AKUMIN HEALTH PLAN				plan number (Fig. 1c Effective date of January 01, 20	of plan
2a	Plan sponsor's name and address, inc plan)	cluding room o	or suite number (Employer, if for a sing	gle-employer	3204	fication Number (EIN)
	AKUMIN 1460 S. VANTAGE WAY SUITE 100 JACKSONVILLE FL 32218				2c Sponsor's telep 416-917-4184 2d Business code 621498	
Und sche	tion: A penalty for the late or incomplet er penalties of perjury and other penalti edules, statements and attachments, as ect, and complete.	es set forth in	the instructions, I declare that I have e	examined this	return/report, includin	
		07/03/2017	ROHIT NAVANI			
•	Signature of plan administrator	Date	Enter name of individual signing as p	olan administra	itor	
	Signature of employer/plan sponsor	Date	Enter name of individual signing as a sponsor	employer or pla	an	
•	Signature of DFE	Date	. Enter name of individual signi	ng as DFE		
For	Paperwork Reduction Act Notice and		<u> </u>	•		Form 5500 (2016)
3a	Plan administrator's name and addres	ss (if same as	plan sponsor, enter"Same")		3b Administrator's 3c Administrator's	

4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:	4	b EIN
	a Sponsor's name	. 4	c PN
5 6	Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines 6a(1), 6a(2), 6b, 6c, and 6d)	5	201
) Total active number of participants at the beginning of the plan year) Total active number of participants at the end of the plan year	6a(1) 6a(2)	200
b C	Retired or separated participants receiving benefits Other retired or separated participants entitled to future benefits	6b 6c	2
d e f g	Subtotal. Add lines 6a(2) , 6b , and 6c Deceased participants whose beneficiaries are receiving or are entitled to receive benefits Total. Add lines 6d and 6e Number of participants with account balances as of the end of the plan year (only defined contribution	6d 6e 6f 6g	289
h	plans complete this item) Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 8a	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) If the plan provides <u>pension benefits</u> , enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:	7	0
(1 (2 (3 (4 10 C instru a P	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4F 4H 4L lan funding arrangement (check all that apply) Section 412(e)(3) insurance C) Section 412(e)(3) insurance contracts Trust C) Section 412(e)(3) insurance C) Section 412(e)(6) insurance C) Section 412(e)(6) insurance C) Section 412(e)(6) insurance C) Section 412(e)(fini	ance contracts sponsor enter the number	
(2 (3 Part 11a 11b	MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information)- signed by the plan actuary SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (6)	tion – Small Planation) Information) Plan Informatio Ition Schedules) In year? (See -2) Yes [It of the 2016 It of the desired to be filed under	n) No er the

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

AKUMIN HEALTH PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

AKUMIN

Part II

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract Part I · on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

BLUE CROSS BLUE SHIELD OF FLORIDA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 98167 B7825 107 01/01/2016 12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$17,609

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 1560 SAWGRASS CORPORATE PKWY #300 SUNRISE FL 33323

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$17,609

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

as a unit for

Investment and Annuity Contract Info	rmation		
Where individual contracts are provided	. the entire group of such individua	I contracts with each	carrier may be treated

purposes of this report.	
4 Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5

6 Contracts With Allocated Funds a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount

Specify nature of costs e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other

Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2)

(3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK D	Ocu insen tiviev	⊈ -£re ∉R& 03/07/18	Page 66 of		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:))				7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuiti	es during year		7e(: 7e(: 7e(: 7e(:	2) 3)	
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa	me group of	employees of the	e same employer(s) or meml	bers of the same	7e(5) 7f	
	art III employee organization(s), the information as a unit. Where contracts cover individua be treated as a unit for purposes of this rep Benefit and contract type (check all applicable b	may be com employees oort.	bined for reporting	ng purposes if such contracts	are experience cts with each carrie		
Ū	a X Health (other than dental or vision)	b Denta	al	c Vision	d [☐Life insura	nce
	Temporary disablility	f□Long-	term disability	g ☐ Supplemental unemp	olovment h	Prescription	n drua
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	ј□нмо	-	k ☑ PPO contract	-	Indemnity	•
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium r				9a(1) 9a(2) 9a(3)	\$440,228	
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves				9b(1) 9b(2)	9a(4) \$339,856	\$440,228
С	(3) Incurred claims (add (1) and (2))(4) Claims chargedRemainder of premium: (1) Retention charges	(on an accru	ual basis) –			9b(3) 9b(4)	\$339,856 \$339,856
	(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs		,		9c(1)(A 9c(1)(B 9c(1)(C)	
	(D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges				9c(1)(D 9c(1)(E 9c(1)(F 9c(1)(G	\$66,860 \$2,696 \$13,207	
d	(H) Total Retention (2) Dividends or retroactive rate refunds. (Thes Status of policyholder reserves at end of year: (2) Claim reserves				, ,	9c(1)(H) 9c(2) 9d(1) 9d(2)	\$100,372
	(3) Other reserves Dividends or retroactive rate refunds due. (Do Nonexperience-rated contracts	not include a	amount entered in	n c(2).)		9d(3) 9e	
	Total premiums or subscription charges paid to If the carrier, service, or other organization incorretention of the contract or policy, other than re Specify nature of costs below:	ırred any sp	ecific costs in co art I, item 2 above	nnection with the acquisition e, report amount	or	10a 10b	
Pa	art IV · Provision of Information						_
11	Did the insurance company fail to provide any	nformation i	necessary to com	plete Schedule A?		□Y€	es 🔀 No

- Did the insurance company fail to provide any information necessary to complete Schedule A?If the answer to line 11 is "Yes," specify the information not provided.

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

AKUMIN HEALTH PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

AKUMIN

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract Part I · on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

HEALTH OPTIONS

(e) Aproximate number of Policy or contract year (d) Contract or persons covered at end of (b) EIN (c) NAIC code identification number (f) From (q) To policy or contract year 3696 95089 B7825 79 01/01/2016 12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$22,307

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 1560 SAWGRASS CORPORATE PKWY #300 SUNRISE FL 33323

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$22,307

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v.092308.1

7c(1)

7c(2)

7c(3)

7c(4)

for

Invest	tme	n	t ar	nd /	Annuity	Contract	t I	nt	OI	rmat	iion

Additions: (1) Contributions deposited during the year

(2) Dividends and credits

(3) Interest credited during the year

(4) Transferred from separate account

P	art II Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated	as a unit
	purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds	
а	state the basis of premium rates	
b	Premiums paid to carrier	6b
С	Premiums due but unpaid at the end of the year	6c
d	I If the carrier, service, or other organization incurred any specific costs in connection with the acquision	6d
	or retention of the contract or policy, enter amount	ou
	Specify nature of costs	
е	Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)	
	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	
	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
а	ı Type of contract (1) ☐ deposit administration (2) ☐ immediate participation guarantee	
	(3) \square guaranteed investment $$ (4) \square other	
b	Balance at the end of the previous year	7b

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK	Docu insent view	₄- ∱re ∉ E	R €0 03/07/18	Page	68 of 9 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6 Deductions:))						7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purc(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	hase annu	ities during year				7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtrace Welfare Benefit Contract Information If more than one contract covers the sart III employee organization(s), the information as a unit. Where contracts cover individua be treated as a unit for purposes of this re	ime group may be co I employee	of employees of the	ng purpo	ses if such contracts	s are ex	perience-		
8	Benefit and contract type (check all applicable based as X Health (other than dental or vision)	oxes) b Der	ntal	c□\	Vision		dГ	Life insura	nce
	e (accident and sickness)		g-term disability		Supplemental unem	nlovment		Prescriptio	
	i ☐ Stop loss (large deductible) m ☐ Other (specify)		O contract		PPO contract	pioymoni		Indemnity	_
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unp. (3) Increase (decrease) in unearned premium r						9a(1) 9a(2) 9a(3)	\$557,666	
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves						9b(1) 9b(2)	9a(4) \$456,728	\$557,666
С	(3) Incurred claims (add (1) and (2))(4) Claims chargedRemainder of premium: (1) Retention charges	(on an acc	crual basis) –				. ,	9b(3) 9b(4)	\$456,728 \$456,728
(A) Commissions (B) Administrative service or other fees 9c(1)(A) \$22 9c(1)(B)					\$22,307				
	(C) Other specific acquisition costs (D) Other expenses (E) Taxes						9c(1)(C) 9c(1)(D) 9c(1)(E)	\$61,901	
	(F) Charges for risks or other contingencies (G) Other retention charges						9c(1)(F) 9c(1)(G)	\$16,730	6400 020
	 (H) Total Retention (2) Dividends or retroactive rate refunds. (Thes Status of policyholder reserves at end of year: (2) Claim reserves (3) Other reserves 	(1) Amour	nt held to provide b	enefits a	credited.) fter retirement			9c(1)(H) 9c(2) 9d(1) 9d(2) 9d(3)	\$100,938
	 e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts 								
	Total premiums or subscription charges paid to If the carrier, service, or other organization inc retention of the contract or policy, other than re Specify nature of costs below:	urred any s				or		10a 10b	
Pa	rt IV · Provision of Information								
11	Did the insurance company fail to provide any	informatio	n necessary to com	nplete Sc	chedule A?			□Y€	es 🔀 No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

01/01/2016

501

12/31/2016

AKUMIN HEALTH PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

71870

D Employer Identification Number (EIN)

AKUMIN

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract Part I · on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

descending order of the amount paid.

FIDELITY SECURITY LIFE INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$972

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

9943572

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

245

(e) Organization code

3

\$972

Schedule A (Form 5500) 2016 v 092308 1

as a unit for

Investment and Annuity Contract Information
Where individual contracts are provided, the entire group of such individual contracts with each corrier may be treated

raitii	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated	as a unit ioi
	purposes of this report.	
4 Curre	nt value of plan's interest under this contract in the general account at year end	4
5 Curre	ent value of plan's interest under this contract in separate accounts at year end	5

6 Contracts With Allocated Funds a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c

d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount Specify nature of costs

e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year

7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2)

(3) Interest credited during the year (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Docu lmen tl ^{vi} e	⊈ -fre ∉R& 03/07/18 Page	70 of 91 7c(5)	L	
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)			7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sai		e same employer(s) or members of th	e same	7e(5) 7f	
	art III employee organization(s), the information of as a unit. Where contracts cover individual be treated as a unit for purposes of this replacement and contract type (check all applicable by	may be combined for reportir employees, the entire group port.	ng purposes if such contracts are ex of such individual contracts with ea	xperience-ra ach carrier n	may	
	a Health (other than dental or vision)	b Dental	c 🔀 Vision	d 🗌	Life insurand	ce
	e	f ☐ Long-term disability	g Supplemental unemployment	h 🗌	Prescription	drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j HMO contract	k ☐ PPO contract	Ι□	Indemnity co	ontract
9 Experience related contracts a Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpaid (3) Increase (decrease) in unearned premium reserve 9a(3)						
b	(4) Earned ((1)+(2)-(3)) b Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves 9b(2)					
	(3) Incurred claims (add (1) and (2)) (4) Claims charged					
С	Remainder of premium: (1) Retention charges	(on an accrual basis) –			9b(4)	
(A) Commissions (B) Administrative service or other fees 9c(1)(A) 9c(1)(B)						
	(C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies			9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F)		
	(G) Other retention charges (H) Total Retention			9c(1)(G)	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	e amounts were \square paid in ca	ash, or C credited.)		9c(2)	
d	d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement (2) Claim reserves (3) Other reserves				9d(1) 9d(2) 9d(3)	
	Dividends or retroactive rate refunds due. (Do I	not include amount entered ir	n c(2).)		9e	
	10 Nonexperience-rated contracts Total promitime or subscription charges poid to corrier (11)					¢11 020
	Total premiums or subscription charges paid to If the carrier, service, or other organization incu- retention of the contract or policy, other than re Specify nature of costs below:	ırred any specific costs in coı			10a 10b	\$11,028
D.	art IV Provision of Information					
-					☐Yes	X No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

AKUMIN HEALTH PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

AKUMIN

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract Part I · on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

FIDELITY SECURITY LIFE INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 71870 9943580 01/01/2016 12/31/2016

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$19

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$19

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

7b

as a unit for

	Investment and Annuity Contract Information
Part II	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated

	purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds	
а	a State the basis of premium rates	
k	b Premiums paid to carrier	6b
C	c Premiums due but unpaid at the end of the year	6c
C	d If the carrier, service, or other organization incurred any specific costs in connection with the acquision	6d
	or retention of the contract or policy, enter amount	ou

Specify nature of costs e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year Additions: (1) Contributions deposited during the year 7c(1)

(2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	2018	5-JGK Docu insen tVi	24 -fr• 4=R& 03/07/18 Pag	e 72 of 91 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6 Deductions:))		7c(6) 7d		
	(1) Disbursed from fund to pay benefits or purc(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	hase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
f	(5) Total deductions Balance at the end of the current year (subtrac Welfare Benefit Contract Information If more than one contract covers the sa	1	the same employer(s) or members of	7e(5) 7f the same		
	art III employee organization(s), the information as a unit. Where contracts cover individua be treated as a unit for purposes of this re Benefit and contract type (check all applicable b	may be combined for repor il employees, the entire grouport.	ting purposes if such contracts are up of such individual contracts with	experience-rated each carrier may		
	a ☐ Health (other than dental or vision)	b Dental	c 🔀 Vision	d Life insura	ance	
	e ☐ Temporary disablility (<u>ac</u> cident and sickness)	f ☐ Long-term disability	g Supplemental unemploymer	nt h \square Prescription	on drug	
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO contract	I ☐ Indemnity	contract	
9 Experience related contracts a Premiums: (1) Amount received 9a(1) (2) Increase (decrease) in amount due but unpaid 9a(2) (3) Increase (decrease) in unearned premium reserve 9a(3)						
b	(4) Earned ((1)+(2)-(3)) b Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves 9b(1) 9b(2)					
	(3) Incurred claims (add (1) and (2)) (4) Claims charged					
С	Remainder of premium: (1) Retention charges	(on an accrual basis) -				
	(A) Commissions (B) Administrative service or other fees 9c(1)(A) 9c(1)(B)					
	(C) Other specific acquisition costs			9c(1)(C)		
	(D) Other expenses (E) Taxes			9c(1)(D) 9c(1)(E)		
	(F) Charges for risks or other contingencies			9c(1)(F)		
	(G) Other retention charges (H) Total Retention			9c(1)(G)		
	(2) Dividends or retroactive rate refunds. (Thes	e amounts were \square naid in a	cash or Credited)	9c(1)(H) 9c(2)		
d	Status of policyholder reserves at end of year:	(1) Amount held to provide	benefits after retirement	9d(1)		
	(2) Claim reserves (3) Other reserves			9d(2) 9d(3)		
е	Dividends or retroactive rate refunds due. (Do	not include amount entered	in c(2).)	9u(3) 9e		
	Nonexperience-rated contracts				* 4 0 0	
	Total premiums or subscription charges paid to If the carrier, service, or other organization inc		onnection with the acquisition or	10a	\$160	
	retention of the contract or policy, other than reported in Part I, item 2 above, report amount Specify nature of costs below:					
Pa	art IV · Provision of Information					
	Did the insurance company fail to provide any	information necessary to co	mplete Schedule A?	□Y	es 🔀 No	

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

01/01/2016

501

12/31/2016

AKUMIN HEALTH PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

64246

D Employer Identification Number (EIN)

AKUMIN

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract Part I · on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information

(a) Name of insurance carrier

THE	CHADDIANI	TEE INTOLIE	ANICE CC		AMEDICA
	GUARDIAN	ニュニー コンシロト	KANCE CC	JIVIPAINT OF	AIVIERICA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 00508238

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid \$1,917

\$9,286

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC ONE INVESTORS WAY NORWOOD MA 02062

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

287

(e) Organization code

\$9,286

\$1,917

FEES

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

as a unit for

Investment	and A	nnuitu	Contract	Informatio	
investment	and A	innuity	Contract	intormatio	Г

	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated	as a unit ioi
	purposes of this report.	
4 Curre	ent value of plan's interest under this contract in the general account at year end	4
C	antivalva of plants interest under this contract in consucts accounts of year and	-

Current value of plan's interest under this contract in separate accounts at year end 6 Contracts With Allocated Funds

a State the basis of premium rates

b Premiums paid to carrier

6b 6c

c Premiums due but unpaid at the end of the year d If the carrier, service, or other organization incurred any specific costs in connection with the acquision or retention of the contract or policy, enter amount

6d

7b

7c(4)

Specify nature of costs

e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

	Contidute vitin on	ancoated i arias (Bo not inolat		
а	Type of contract	(1) deposit administration	(2) immediate participation guarantee	Э

	(3) Liguaranteed investment (4) Light other
)	Balance at the end of the previous year
;	Additions: (1) Contributions deposited during the year

7c(1) (2) Dividends and credits 7c(2) (3) Interest credited during the year (4) Transferred from separate account

http://freeerisa.benefitspro.com/5500/formprint.aspx?DLN=20170703083441P030000988569001

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	i-JGK Doculmaterntt∿	<u>/'₱¥-fre</u> ¶₽ <mark>₽4</mark> 03/07/18	Page 74 of 9		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:))			7c(6) 7d	
-	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	hase annuities during year		7e(1) 7e(2) 7e(3) 7e(4))	
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information	1			7e(5) 7f	
	If more than one contract covers the sa art III employee organization(s), the information as a unit. Where contracts cover individua be treated as a unit for purposes of this re	may be combined for repo I employees, the entire gro port.	rting purposes if such contract	nbers of the same ts are experience-i acts with each carrier		
8	Benefit and contract type (check all applicable be a Health (other than dental or vision)	b Dental	c ☐ Vision	d 🔀	Life insurar	nce
	Temporary disablility	f X Long-term disability			Prescription	
	(<u>ac</u> cident and sickness)			-	•	•
	i ☐ Stop loss (large deductible) m ☑ Other (specify) ACCIDENTAL DEATH AN	j ☐ HMO contract ID DISMEMBERMENT	k ☐ PPO contract	'_	Indemnity	contract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa	aid		9a(1) 9a(2)		
	(3) Increase (decrease) in unearned premium r	reserve		9a(3)		
h	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid			9b(1)	9a(4)	
D	(2) Increase (decrease) in claim reserves			9b(2)		
	(3) Incurred claims (add (1) and (2))			,	9b(3)	
_	(4) Claims charged	(9b(4)	
C	Remainder of premium: (1) Retention charges (A) Commissions	(on an acciual basis) –		9c(1)(A)		
	(B) Administrative service or other fees			9c(1)(B)		
	(C) Other specific acquisition costs			9c(1)(C)		
	(D) Other expenses (E) Taxes			9c(1)(D) 9c(1)(E)		
	(F) Charges for risks or other contingencies			9c(1)(F)		
	(G) Other retention charges			9c(1)(G)	0-(4)(11)	
	(H) Total Retention(2) Dividends or retroactive rate refunds. (Thes	o amounts were \square naid in	each or Caraditad)		9c(1)(H) 9c(2)	
d	Status of policyholder reserves at end of year:				9d(1)	
	(2) Claim reserves	.,			9d(2)	
	(3) Other reserves Dividends or retroactive rate refunds due. (Do	not include amount entere	d in c(2))		9d(3) 9e	
	Nonexperience-rated contracts	not include amount entere	u III 6(2).)		36	
	Total premiums or subscription charges paid to				10a	\$92,861
b	If the carrier, service, or other organization incorretention of the contract or policy, other than respecify nature of costs below:	urred any specific costs in eported in Part I, item 2 abo	connection with the acquisitior ove, report amount	n or	10b	
D.	art IV · Provision of Information					
	Did the insurance company fail to provide any	information necessary to c	omplete Schedule A?		□Ye	es 🔀 No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

OMB No. 1210 - 0110

This Form is Open to Public Inspection

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning January 01, 2016, and ending December 31, 2016 A Name of plan

B Three-digit plan number (PN)

501

12/31/2016

AKUMIN HEALTH PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

73288

D Employer Identification Number (EIN)

AKUMIN

Part II

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract Part I on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

HUMANA INSURANCE COMPANY

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

01/01/2016

\$6,342

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

749790

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

173

(e) Organization code

\$6,342

(4) Transferred from separate account

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

6b

7c(4)

as a unit for

Investment and Annuity Contract Information				
	Investment	and Annuity	v Contract	Information

	purposes of this report.	
ļ	Current value of plan's interest under this contract in the general account at year end	4
5	6 Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts With Allocated Funds	
á	a State the basis of premium rates	

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated

b Premiums paid to carrier c Premiums due but unpaid at the end of the year

6c d If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount

Specify nature of costs e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) Type of contract (1) deposit administration

u	Type of continue	(1) ueposit aurillistration	(2) ininediate participation guarantee
		(3) guaranteed investment	(4) Other
h	Balance at the e	nd of the previous year	

7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2) (3) Interest credited during the year

http://freeerisa.benefitspro.com/5500/formprint.aspx?DLN=20170703083441P030000988569001

3/6/2	2018 Case 1:18-cv-01805- (5) Other (specify below)	-JGK Docu insen tt ^v i⊵v	!- £re ∉R&d 03/07/18 Page	76 of 93	1	
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:)			7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	ase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sar rt III employee organization(s), the information in as a unit. Where contracts cover individual	ne group of employees of the nay be combined for reportin employees, the entire group	g purposes if such contracts are ex	cperience-ra		
8	be treated as a unit for purposes of this rep Benefit and contract type (check all applicable bo					
	a ☐ Health (other than dental or vision)	b 🔀 Dental	c ☐ Vision	d 🗌	Life insurance	е
	e ☐ Temporary disablility (accident and sickness)	f ☐ Long-term disability	g Supplemental unemployment	h 🗌	Prescription of	drug
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract	k ☐ PPO contract	Ι□	Indemnity co	ntract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re			9a(1) 9a(2) 9a(3)	92(4)	
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid			9b(1)	9a(4)	
	(2) Increase (decrease) in claim reserves			9b(2)	0b/2)	
	(3) Incurred claims (add (1) and (2)) (4) Claims charged				9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis) –		0=(4)(A)		
	(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs			9c(1)(A) 9c(1)(B) 9c(1)(C)		
	(D) Other expenses (E) Taxes			9c(1)(D) 9c(1)(E)		
	(F) Charges for risks or other contingencies (G) Other retention charges			9c(1)(F) 9c(1)(G)		
	(H) Total Retention(2) Dividends or retroactive rate refunds. (These	amounts were Unaid in ca	sh or Credited)		9c(1)(H) 9c(2)	
d	Status of policyholder reserves at end of year: (2) Claim reserves	(1) Amount held to provide be	enefits after retirement		9d(1) 9d(2)	
е	(3) Other reserves Dividends or retroactive rate refunds due. (Do n	not include amount entered ir	n c(2).)		9d(3) 9e	
10	Nonexperience-rated contracts		· //		40	000 500
	Total premiums or subscription charges paid to If the carrier, service, or other organization incu retention of the contract or policy, other than rep Specify nature of costs below:	rred any specific costs in cor			10a \$	68,503
Pa	rt IV · Provision of Information					
11	Did the insurance company fail to provide any ir If the answer to line 11 is "Yes," specify the information of the insurance company fail to provide any ir If the answer to line 11 is "Yes," specify the information of the insurance company fail to provide any ir If the		plete Schedule A?		Yes	X No



Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Signature of plan administrator

Signature of employer/plan sponsor

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210 - 0110 1210 - 0089

2016

This Form is Open to Public Inspection

	t I· Annual Report Identification Information calendar plan year 2016 or fiscal plan year beginning <mark>April 01, 2016</mark> , and ending <mark>Ma</mark> i	rch 31, 2017				
А а	multiple-employer plan (Filers checking this box must attach a list of participating mployer information in accordance with the form instructions)for	a multiemploye plan; a single-employer pla		☐ a multiple-e ☐ a DFE (spe		plan;
ВТ	his return/report is:	the first return/report; an amen return/report;		the final return/report (les months).	year .	
C If	the plan is a collectively-bargained plan, check here	_		_	_	
D C	check box if filling under:	Form 55	58;	automatic extension;	prog	the DFVC ram;
		☐ special e	xtens	sion (enter descripti	on)	
Par	t II · Basic Plan Information – enter all requested information.					
1a	Name of plan DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN			Three-digit plan number (PN)		501
	DOFFT 3 SPORTS GRILL HEALTH AND WELFARE FLAN		10	Effective date of p February 01, 200		
2a	Plan sponsor's name and address, including room or suite number (Employer, if for a single)	gle-employer		Employer Identifica		, ,
	DUFFY'S SPORTS GRILL		2c	Sponsor's telephor 561-585-6685	ne numb	er
	1926 10TH AVENUE NORTH, SUITE 300 LAKE WORTH FL 33461		2d	Business code (se 722511	e instrud	ctions)
Und sche	tion: A penalty for the late or incomplete filing of this return/report will be assessed unless er penalties of perjury and other penalties set forth in the instructions, I declare that I have studies, statements and attachments, as well as the electronic version of this return/report, a ect, and complete.	examined this	retur	n/report, including a	ecompa	anying s true,

Enter name of individual signing as plan

administrator

Enter name of individual signing as employer or

plan sponsor

Signature of DFE Date Enter name of individual signing as DFE

Date

Date

Form 5500 (2016) v.092308.1

- For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

 3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
- **3b** Administrator's EIN
- **3c** Administrator's telephone number

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:		b EIN
a Sponsor's name	. 4	c PN
Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines 6a(1), 6a(2), 6b, 6c, and 6d)	· 5 ·	340
Total active number of participants at the beginning of the plan year	6a(1) 6a(2)	339
	6b	3
		240
		346
Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
	7	0
If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:		
Characteristics Codes in the instructions: 4A 4B 4D 4E 4F 4L Insurance Section 412(e)(3) insurance contracts Section 412(e)(3) insurance contracts General assets of the sponsor (1)	rance contracts sponsor enter the number tion) tion – Small Plan ation) Plan Information tion Schedules) n year? (See -2) Yes [o file the 2016 to be filed unde	er attached (See n) No
	Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines 6a(1), 6a(2), 6b, 6c, and 6d) Total active number of participants at the beginning of the plan year Total active number of participants at the end of the plan year Total active number of participants at the end of the plan year Total active number of participants are receiving benefits Other retired or separated participants receiving benefits Other retired or separated participants receiving benefits Other retired or separated participants receiving benefits Subtotal. Add lines 6a(2), 6b, and 6c Deceased participants whose beneficiaries are receiving or are entitled to receive benefits Total. Add lines 6a and 6e Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) If the plan provides <u>pension benefits</u> , enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: If the plan provides <u>welfare benefits</u> , enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: (1) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor heck all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, including arrangement (check all policable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, including a plan actuary (5) Section 412(e)(3) insurance contracts (6) Ginancial Information) (7) RB (Single-Employer Defined Benefit Plan and Certain Money Purch	a Sponsor's name Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year unless otherwise stated (welfare plans only complete lines Sa(1), 6a(2), 6b, 6c, and 6d) Total active number of participants at the beginning of the plan year Viola active number of participants at the beginning of the plan year Total active number of participants at the beginning of the plan year Total active number of participants at the beginning of the plan year Total active number of participants receiving benefits Getalload. Add lines 6a(2), 6b, and 6c Subtotal. Add lines 6a(3), 6b, and 6c Subtotal. Add lines 6a(3), 6b, and 6c Subtotal Add lines 6a(2), 6b, and 6c Subtotal Add lines 6a(3), 6b, and 6c Subtotal Add lines 6a(2), 6b, and 6c Subtotal Add lines 6a(3), 6b, and 6c Subtotal Add lines 6a(2), 6b, and 6c

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

This Form is Open to Public Inspection

OMB No. 1210 - 0110

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017 A Name of plan

B Three-digit plan number (PN)

501

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

DUFFY'S SPORTS GRILL

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

BLUE CROSS BLUE SHIELD OF FLORIDA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 5694 98167 B8302 283 04/01/2016 03/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$72,242

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 1560 SAWGRASS CORPORATE PKWY SUITE SUNRISE FL 33323

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$72,242

Balance at the end of the previous year

(3) Interest credited during the year

(4) Transferred from separate account

(2) Dividends and credits

Additions: (1) Contributions deposited during the year

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v.092308.1

7b

7c(1)

7c(2)

7c(3)

7c(4)

Investment and Annuity Contract Information	
Part II • Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated	as a unit for
purposes of this report.	
4 Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5
6 Contracts With Allocated Funds	
a State the basis of premium rates	
b Premiums paid to carrier	6b
c Premiums due but unpaid at the end of the year	6c
d If the carrier, service, or other organization incurred any specific costs in connection with the acquision	6d
or retention of the contract or policy, enter amount	ou
Specify nature of costs	
e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)	
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a Type of contract (1) deposit administration (2) immediate participation guarantee	
(3) ☐ guaranteed investment (4) ☐ other	

3/6/	Case 1:18-cv-01805 (5) Other (specify below)	-JGK D	OCU INSTEIN TUE	-£re ∉Red 03/07/18	•	of 91 'c(5)	
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)				7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuitie	es during year		7 7	'e(1) 'e(2) 'e(3) 'e(4)	
	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa Int III employee organization(s), the information	me group of may be com	employees of the bined for reporting	g purposes if such contracts	are experier	7e(5) 7f ame nce-rated	
8	as a unit. Where contracts cover individua be treated as a unit for purposes of this re Benefit and contract type (check all applicable b	oort. oxe <u>s)</u>		of such individual contrac c □ Vision			
	a Health (other than dental or vision) Temporary disablility	b ∐ Denta		_		d ☐ Life insur	
	(accident and sickness)		term disability	g ☐ Supplemental unemp	loyment	h X Prescripti	_
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	ј□нмо	contract	k 🔀 PPO contract		I ☐ Indemnity	contract
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpot (3) Increase (decrease) in unearned premium r				9a(1 9a(2 9a(3)	
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves				9b(1 9b(2		
С	(3) Incurred claims (add (1) and (2))(4) Claims chargedRemainder of premium: (1) Retention charges	(on an accru	ıal basis) –			9b(3) 9b(4)	\$1,094,605 \$1,094,605
	(A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs	(,		9c(1)(, 9c(1)() 9c(1)(B)	
	(D) Other expenses (E) Taxes (F) Charges for risks or other contingencies				9c(1)(9c(1)(9c(1)(D) \$178,292 E) \$8,669 F) \$91,024	
	(G) Other retention charges(H) Total Retention(2) Dividends or retroactive rate refunds. (Thes				9c(1)(9c(1)(H) 9c(2)	\$350,227
	Status of policyholder reserves at end of year: (2) Claim reserves (3) Other reserves					9d(1) 9d(2) 9d(3)	
	Dividends or retroactive rate refunds due. (Do Nonexperience-rated contracts	not include a	imount entered in	C(2).)		9e	
а	Total premiums or subscription charges paid to If the carrier, service, or other organization incretention of the contract or policy, other than respecify nature of costs below:	irred any spe	ecific costs in con rt I, item 2 above,	nection with the acquisition or report amount	or	10a 10b	
Pa	rt IV · Provision of Information						
11	Did the insurance company fail to provide any	nformation r	ecessary to comp	plete Schedule A?			′es 🔀 No

SCHEDULE A Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

2016

This Form is Open to Public Inspection

D Employer Identification Number (EIN)

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017 A Name of plan

B Three-digit plan number (PN)

501

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

JU 1

DUFFY'S SPORTS GRILL

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY

(b) EIN

(c) NAIC code

(d) Contract or identification number (e) Aproximate number of persons covered at end of policy or contract year

Policy or contract year

(f) From

(g) To

4607

62049

E3950466

2

04/01/2016

03/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$98

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (c) Amount (d) Purp

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

(d) Purpose

(e) Organization code

3

\$65

CREATIVE BENEFIT CONSULTANTS INC 18214 102ND WAY S BOCA RATON FL 33498

(b) Amount of sales and base commissions paid

Fees and other commissions paid (c) Amount (d) Purpose

(e) Organization code

\$17

3

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

STALTARE BENEFITS INC 700 E ATLANTIC BLVD POMPANO BEACH FL 33060

(b) Amount of sales and base commissions paid

Fees and other commissions paid (c) Amount (d) Purpose

(e) Organization code

\$16

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v.092308.1

_	Investment and Annuity Contract Info	rmation				
P	 Where individual contracts are provided, purposes of this report. 	, the entire group of such ind	lividual contracts with each carrier may	/ be treated	l as a un	it for
	Current value of plan's interest under this contrac				4	
	Current value of plan's interest under this contrac	t in separate accounts at yea	ar end		5	
	Contracts With Allocated Funds State the basis of premium rates					
	Premiums paid to carrier				6b	
	Premiums due but unpaid at the end of the year If the carrier, service, or other organization incur		nection with the acquision		6c	
u	or retention of the contract or policy, enter amou		nection with the acquision		6d	
	Specify nature of costs		(D) () ()			
	Type of contract (1) individual policies (2)					
	If contract purchased, in whole or in part, to distr Contracts With Unallocated Funds (Do not include					
	Type of contract (1) deposit administration					
	(3) 🔲 guaranteed investment	(4) other	_			
	Balance at the end of the previous year Additions: (1) Contributions deposited during the	ne vear		7c(1)	7b	
·	(2) Dividends and credits	ic year		7c(2)		
	(3) Interest credited during the year			7c(3)		
	(4) Transferred from separate account (5) Other (specify below)			7c(4) 7c(5)		
	(c) cance (cpccar) second					
	(6) Total additions				7c(6)	
	Total of balance and additions (add b and c (6)) Deductions:				7d	
	(1) Disbursed from fund to pay benefits or purch	ase annuities during year		7e(1)		
	(2) Administration charge made by carrier (3) Transferred to separate account			7e(2) 7e(3)		
	(4) Other (specify below)			7e(3)		
	(C) T-4-1 d- d				7-(5)	
f	(5) Total deductions Balance at the end of the current year (subtract	e (5) from d)			7e(5) 7f	
	Welfare Benefit Contract Information					
	If more than one contract covers the sar art III employee organization(s), the information n as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable bo	nay be combined for reportir employees, the entire group ort.	ng purposes if such contracts are ex	kperience-ra		
•		b Dental	c ☐ Vision	d 🗌	Life insurar	nce
	e M Temporary disability	f ☐ Long-term disability	g Supplemental unemployment	h□	Prescription	n drug
	(accident and sickness) i □ Stop loss (large deductible)	i ☐ HMO contract	k ☐ PPO contract		Indemnity of	-
	m Other (specify)	-	, _		,	
9	Experience related contracts					
	Premiums: (1) Amount received			9a(1)		
	(2) Increase (decrease) in amount due but unpa			9a(2)		
	(3) Increase (decrease) in unearned premium re(4) Earned ((1)+(2)-(3))	serve		9a(3)	9a(4)	
b	Benefit charges: (1) Claims paid			9b(1)	. ,	
	(2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2))			9b(2)	9b(3)	
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (on an accrual basis) –		0-(4)(A)		
	(A) Commissions (B) Administrative service or other fees			9c(1)(A) 9c(1)(B)		
	(C) Other specific acquisition costs			9c(1)(C)		
	(D) Other expenses (E) Taxes			9c(1)(D) 9c(1)(E)		
	(F) Charges for risks or other contingencies			9c(1)(F)		
	(G) Other retention charges			9c(1)(G)	0-(4)(1)	
	(H) Total Retention(2) Dividends or retroactive rate refunds. (These	amounts were English to	sh or credited)		9c(1)(H) 9c(2)	
d	Status of policyholder reserves at end of year: (9d(1)	
	(2) Claim reserves	·			9d(2)	
e	(3) Other reservesDividends or retroactive rate refunds due. (Do n	ot include amount entered in	n c(2).)		9d(3) 9e	
10	Nonexperience-rated contracts		<i>():1</i>			
	Total premiums or subscription charges paid to If the carrier, service, or other organization incu		anaction with the acquisition or		10a 10b	\$1,501
IJ	ii uio vailiei, seivive, vi vulti vivaliizauvii liiku	a and olill 60313 iii 601	micodon with the acquisition of		100	

3/6/2018 Case 1:18-cv-01805-JGK Doculnstent / iput = freq FREA 03/07/18 Page 84 of 91

retention of the contract or policy, other than reported in Part I, item 2 above, report amount Specify nature of costs below:

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?

12 If the answer to line 11 is "Yes," specify the information not provided.

Yes X No

SCHEDULE A Form 5500

Department of the Treasury

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500

OMB No. 1210 - 0110

	I Revenue Service	— File as an a	ittachment to Form 5500.	This Form is	Open to Public
Employee Bene	artment of Labor fits Security Administration efit Guaranty Corporation		Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).		
		olan year beginning April 01.	2016, and ending March 31, 2017		
A Name of plan	p.a you. =0.00 01 1100a.	, and the second		B Three-digit	
				plan number (PN)	501
DUFFY'S SPOF	RTS GRILL HEALTH AND	WELFARE PLAN			
C Plan sponsor's	name as shown on line 2a	of Form 5500		D Employer Identificat	ion Number (EIN)
DUFFY'S SPOF	RTS GRILL				
	parate Schedule A. Individ mation		and Commissions.Provide information Parts II and III can be reported on		
		FIDELITY SECURITY LIF	E INSURANCE COMPANY		
			(e) Aproximate number of	Policy or co	intract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	(g) To
9844	71870	97480211001	148	04/01/2016	03/31/2017
2 Insurance fee ar	nd commission information	Enter the total fees and total of	commissions paid. List in item 3 the	agents brokers and of	her nersons in
	of the amount paid.	Emer the total roos and total t	seriminediene paia. Elet in item e the t	agomo, bronoro, and ou	ioi poroono iii
	(a) Total amount of comm	nissions paid	(b) Total an	nount of fees paid	
	\$991				
3 Persons receivi		(Complete as many entries as lress of the agent, broker or oth	needed to report all persons). er person to whom commissions or	fees were paid	
		4565 PAYSP	AND BENEFITS, LLC HERE CIRCLE O IL 60674		
(b) A	mount of sales and base	Fees	and other commissions paid	(e) Org	<u>anization</u>
` ,	commissions paid	(c) Amour	•		ode
	\$991				<u>3</u>
For Paperwork R	eduction Act Notice and	OMB Control Numbers, see t	the instructions for Form 5500.	Schedule A (I	Form 5500) 2016 v.092308.1
Part II Where	tment and Annuity Contre e individual contracts are p of this report.		h individual contracts with each carr	ier may be treated a	s a unit for
		contract in the general account	at year end		4
5 Current value o6 Contracts With	f plan's interest under this Allocated Funds	contract in separate accounts a			5
	s of premium rates				O.L.
b Premiums paid	d to carrier e but unpaid at the end of t	he vear			6b 6c
d If the carrier.	service, or other organization	ne year on incurred any specific costs ir	connection with the acquision		
	, 	, 5,5555 55666 11			6d

or retention of the contract or policy, enter amount Specify nature of costs (2) group deferred annuity (3) other (specify) e Type of contract (1) ☐ individual policies f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other **b** Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2) (3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Docu	instentt Vi ⊵4 -:	Ere 4ERI& 03/07/18	Page 86 of		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:)				7c(6) 7d	
•	(1) Disbursed from fund to pay benefits or purch(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	nase annuities dui	ring year		7e(* 7e(* 7e(* 7e(*	2) 3)	
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information		over of the o	ama amplayar(a) ar mamb	ore of the	7e(5) 7f	
	If more than one contract covers the sa art III employee organization(s), the information as a unit. Where contracts cover individual be treated as a unit for purposes of this rep Benefit and contract type (check all applicable b	may be combined employees, the eport.	for reporting	purposes if such contracts	are experience	-rated	
Ü	a ☐ Health (other than dental or vision)	b Dental		c X Vision	d [Life insurar	nce
	Temporary disablility	f ☐ Long-term	disability	g Supplemental unempl	lovment h	Prescription	n drua
	(accident and sickness) i ☐ Stop loss (large deductible)	j HMO contra	=	k ☐ PPO contract	-	Indemnity of	•
	m Other (specify)	, mrivio contro	aot	и <u>Птто contract</u>	• •		Sontiact
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpa (3) Increase (decrease) in unearned premium re (4) Earned ((1)+(2)-(3))				9a(1) 9a(2) 9a(3)	9a(4)	
	Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred claims (add (1) and (2)) (4) Claims charged				9b(1) 9b(2)	9b(3) 9b(4)	
С	Remainder of premium: (1) Retention charges (A) Commissions (B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges	(on an accrual ba	sis) –		9c(1)(A 9c(1)(B 9c(1)(C 9c(1)(D 9c(1)(E 9c(1)(F 9c(1)(G))))	
	 (H) Total Retention (2) Dividends or retroactive rate refunds. (These Status of policyholder reserves at end of year: (2) Claim reserves (3) Other reserves Dividends or retroactive rate refunds due. (Do 	(1) Amount held t	o provide ben	efits after retirement		9c(1)(H) 9c(2) 9d(1) 9d(2) 9d(3) 9e	
	Nonexperience-rated contracts	carrier				102	¢13 362
	Total premiums or subscription charges paid to If the carrier, service, or other organization incuretention of the contract or policy, other than re Specify nature of costs below:	irred any specific	costs in conne em 2 above, re	ection with the acquisition c eport amount	or	10a 10b	\$13,363
Pá	art IV · Provision of Information						
11	Did the insurance company fail to provide any i	nformation neces	sary to comple	ete Schedule A?		□Ye	s 🔀 No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Pension Benefit Guaranty Corporation

Department of Labor Employee Benefits Security Administration **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

158

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

This Form is Open to Public Inspection

D Employer Identification Number (EIN)

OMB No. 1210 - 0110

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017 A Name of plan

B Three-digit plan number (PN)

04/01/2016

501

03/31/2017

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

64246

DUFFY'S SPORTS GRILL

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

3390

THE GUARDIAN L	IFF INSURANCE	COMPANY OF	AMERICA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in

descending order of the amount paid.

(a) Total amount of commissions paid (b) Total amount of fees paid

> \$7,863 \$646

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

00476398

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC ONE INVESTORS WAY NORWOOD MA 02062

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$7,863

\$646

FEES PAID

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

7b

Investment	and An	nuity Cດ	ntract l	nformation

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report. 4 Current value of plan's interest under this contract in the general account at year end 5

Current value of plan's interest under this contract in separate accounts at year end

6 Contracts With Allocated Funds a State the basis of premium rates

b Premiums paid to carrier 6b c Premiums due but unpaid at the end of the year 6c

If the carrier, service, or other organization incurred any specific costs in connection with the acquision 6d or retention of the contract or policy, enter amount

Specify nature of costs e Type of contract (1) ☐ individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year

Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2) (3) Interest credited during the year

(4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805 (5) Other (specify below)	-JGK Docu l n⁴	ent(Vi<u>e</u>v4- Tre dER (9 d 03/07/18	Page 88 of 9 7c(5)		
	(6) Total additions Total of balance and additions (add b and c (6) Deductions:))				7c(6) 7d	
Ū	 (1) Disbursed from fund to pay benefits or purc (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below) 	hase annuities during	year		7e(1) 7e(2) 7e(3) 7e(4)		
f	(5) Total deductions Balance at the end of the current year (subtract Welfare Benefit Contract Information If more than one contract covers the sa	1	es of the same em	plover(s) or memb	ers of the same	7e(5) 7f	
	art III employee organization(s), the information as a unit. Where contracts cover individua be treated as a unit for purposes of this re Benefit and contract type (check all applicable b	may be combined for I employees, the entil port.	reporting purpose	s if such contracts	are experience-r ts with each carrier		
Ŭ	a ☐ Health (other than dental or vision)	b X Dental	c □ Vis	ion	d 🗆	Life insuranc	ce
	e ☐ Temporary disablility	f ☐ Long-term disa	abilitv q ∏ Su	pplemental unemp	lovment h	Prescription	drua
	i ☐ Stop loss (large deductible) m ☐ Other (specify)	j ☐ HMO contract		O contract	-	Indemnity co	•
	Experience related contracts Premiums: (1) Amount received (2) Increase (decrease) in amount due but unpount (3) Increase (decrease) in unearned premium relations.				9a(1) 9a(2) 9a(3)		
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid (2) Increase (decrease) in claim reserves (3) Incurred charge (add (1) and (2))				9b(1) 9b(2)	9a(4) 9b(3)	
С	(4) Claims charged Remainder of premium: (1) Retention charges (A) Commissions	(on an accrual basis)	-		9c(1)(A)	9b(4)	
	(B) Administrative service or other fees (C) Other specific acquisition costs (D) Other expenses (E) Taxes (F) Charges for risks or other contingencies (G) Other retention charges				9c(1)(B) 9c(1)(C) 9c(1)(D) 9c(1)(E) 9c(1)(F) 9c(1)(G)		
d	(H) Total Retention (2) Dividends or retroactive rate refunds. (Thes Status of policyholder reserves at end of year: (2) Claim reserves				23()(2)	9c(1)(H) 9c(2) 9d(1) 9d(2)	
	(3) Other reserves Dividends or retroactive rate refunds due. (Do Nonexperience-rated contracts	not include amount e	ntered in c(2).)			9d(3) 9e	
а	Total premiums or subscription charges paid to If the carrier, service, or other organization incretention of the contract or policy, other than re Specify nature of costs below:	urred any specific cos			or	10a 10b	\$78,595
P:	art IV · Provision of Information						
	Did the insurance company fail to provide any	information necessar	y to complete Sche	edule A?		Yes	🔀 No

SCHEDULE A Form 5500

Department of the Treasurv Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA)

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210 - 0110

This Form is Open to Public Inspection

For the calendar plan year 2016 or fiscal plan year beginning April 01, 2016, and ending March 31, 2017 A Name of plan

B Three-digit plan number (PN)

501

DUFFY'S SPORTS GRILL HEALTH AND WELFARE PLAN

C Plan sponsor's name as shown on line 2a of Form 5500

D Employer Identification Number (EIN)

DUFFY'S SPORTS GRILL

Information Concerning Insurance Contract Coverage, Fees, and Commissions. Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

- 1 Coverage Information
- (a) Name of insurance carrier

SUN LIFE ASSURANCE COMPANY OF CANADA

(e) Aproximate number of Policy or contract year (d) Contract or (b) EIN (c) NAIC code persons covered at end of identification number (f) From (q) To policy or contract year 80802 243948 240 04/01/2016 03/31/2017

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid

(b) Total amount of fees paid

\$3,456

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker or other person to whom commissions or fees were paid

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO IL 60674

(b) Amount of sales and base commissions paid

Fees and other commissions paid (d) Purpose (c) Amount

(e) Organization code

\$3,456

3

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2016 v 092308 1

as a unit for

	Investment and Annuity Co	ontract Information	
Part II	Where individual contracts a	re provided, the entire group of such individual contracts with each carrier may be treated	t

or retention of the contract or policy, enter amount

purposes of this report.	
Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5
6 Contracts With Allocated Funds	
a State the basis of premium rates	
b Premiums paid to carrier	6b
c Premiums due but unpaid at the end of the year	6c
d If the carrier, service, or other organization incurred any specific costs in connection with the acquision	6d
	o u

Specify nature of costs e Type of contract (1) individual policies (2) group deferred annuity (3) other (specify)

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) deposit administration (2) immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other Balance at the end of the previous year 7b Additions: (1) Contributions deposited during the year 7c(1) (2) Dividends and credits 7c(2)

(3) Interest credited during the year 7c(3) (4) Transferred from separate account 7c(4)

3/6/	2018 Case 1:18-cv-01805- (5) Other (specify below)	JGK Doculmaentt√ieva	!-1 ^{re} ∉Re∕d 03/07/18 Page	90 of 91 7c(5)	L	
	(6) Total additions Total of balance and additions (add b and c (6)) Deductions:				7c(6) 7d	
	(1) Disbursed from fund to pay benefits or purch:(2) Administration charge made by carrier(3) Transferred to separate account(4) Other (specify below)	ase annuities during year		7e(1) 7e(2) 7e(3) 7e(4)		
	(5) Total deductions Balance at the end of the current year (subtract welfare Benefit Contract Information If more than one contract covers the san	ne group of employees of the	e same employer(s) or members of the	e same	7e(5) 7f	
	art III employee organization(s), the information n as a unit. Where contracts cover individual be treated as a unit for purposes of this repose Benefit and contract type (check all applicable bo	nay be combined for reportinemployees, the entire group ort. (xes)	g purposes if such contracts are ex of such individual contracts with ea	xperience-ra ach carrier n	nay	
	_ \	b ☐ Dental	c Vision	· <u></u> -	Life insurand	
	e	f ☐ Long-term disability	g Supplemental unemployment	h 🔲	Prescription	drug
	i ☐ Stop loss (large deductible) m ☑ Other (specify) ACCIDENTAL DEATH AND	j ☐ HMO contract D DISMEMBERMENT EMPL		Ι□Ι	Indemnity co	ontract
	Experience related contracts Premiums: (1) Amount received			9a(1)		
ű	(2) Increase (decrease) in amount due but unpai	d		9a(2)		
	(3) Increase (decrease) in unearned premium re	serve		9a(3)	0-(4)	
b	(4) Earned ((1)+(2)-(3)) Benefit charges: (1) Claims paid			9b(1)	9a(4)	
-	(2) Increase (decrease) in claim reserves			9b(2)		
	(3) Incurred claims (add (1) and (2))				9b(3)	
c	(4) Claims charged Remainder of premium: (1) Retention charges (on an accrual hasis) –			9b(4)	
Ŭ	(A) Commissions	on an addition badio)		9c(1)(A)		
	(B) Administrative service or other fees			9c(1)(B)		
	(C) Other specific acquisition costs (D) Other expenses			9c(1)(C) 9c(1)(D)		
	(E) Taxes			9c(1)(E)		
	(F) Charges for risks or other contingencies			9c(1)(F)		
	(G) Other retention charges			9c(1)(G)	0-(4)(1)	
	(H) Total Retention(2) Dividends or retroactive rate refunds. (These	amounta wara Dhaid in ac	ab ar araditad)		9c(1)(H) 9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide be	enefits after retirement		9d(1)	
	(2) Claim reserves	.,			9d(2)	
	(3) Other reserves		(0)		9d(3)	
	Dividends or retroactive rate refunds due. (Do n Nonexperience-rated contracts	ot include amount entered in	I C(∠).)		9e	
	Total premiums or subscription charges paid to	carrier			10a	\$29,211
	If the carrier, service, or other organization incurrentention of the contract or policy, other than rep Specify nature of costs below:	rred any specific costs in con			10b	
	opeony nature or costs below.					
	art IV Provision of Information					
11	Did the insurance company fail to provide any ir	formation necessary to com	plete Schedule A?		☐ Yes	🔀 No